HEALTH NEW ENGLAND

MEMBER HANDBOOK FOR THE COMMONWEALTH OF MASSACHUSETTS

GROUP INSURANCE COMMISSION

EFFECTIVE JULY 1, 2005

(Amended Effective July 1, 2006)

MEDICARE ENROLLED RETIREES

Interpreter and Translation Services

HNE will provide Members, upon request, interpreter and translation services related to administrative procedures. If you need translation services, just tell the Member Services representative when you call. Then during your call, we will use the AT&T Language Line Service to reach an interpreter who will help us answer your questions.

(Arabic)

ستؤمِّن HNE للأعضاء مترجما فوريا وخدمات ترجمة تتعلق بالإجراءات الإدارية وذلك بناء على طلب هؤلاء الأعضاء. فإذا كنت بحاجة إلى خدمات ترجمة، فما عليك إلا أن تقوم بإعلام ممثل خدمات الأعضاء بذلك عندما تجري مكالمة هاتفية، فنقوم، أثناء مكالمتك الهاتفية هذه، بالاستعانة بشركة Language Line Services للوصول إلى مترجم فوري يساعدنا على الإجابة على أسئلتك.

(Cambodian: Khmer)

HNE នឹងផ្តល់ឲ្យសមាជិករទៅតាមសំណូមពររបស់គេនូវកិច្ចបំរើខាងបកប្រែភាសានិងលើក្រដាសដែលជាប់ទាក់ទងនិងដំណើរការ ខារដ្ឋបាល ។ បើអ្នកត្រូវការកិច្ចបំរើខាងការបកប្រែ គ្រាន់តែប្រាប់អ្នកតំណាងខាងបំរើសមាជិក នៅពេលដែលអ្នកទូរស័ព្ទទៅគេ ។ បន្ទាប់មក នៅក្នុងពេលដែលអ្នកទូរស័ព្ទនោះ យើងនឹងប្រើកិច្ចបំរើខាងភាសាតាមទូរស័ព្ទ (Language Line Services) បន្តភ្ជាប់ទៅអ្នកបកប្រែ ដែលនឹងជួយយើងដើម្បីឆ្លើយនិងសំនួរ របស់អ្នក ។

(Cantonese)

HNE 將應請求爲會員提供 與行政程序相關的傳譯及翻譯服務。如果您需要翻譯服務，只需於來電時告知會員服務代表。然後，通話時，我們將使用 Language Line Services 聯絡一名傳譯員，該名傳譯員將協助我們回答您的問題。

(French)

HNE fournira aux membres des services d'interprétation et de traduction pour les procédures administratives sur demande. Si vous avez besoin de traduction, dites-le au représentant du Service des membres quand vous appelez. Au cours de votre appel, nous utiliserons alors Language Line Services afin de contacter un interprète qui nous aidera à répondre à vos questions.

(Greek)

Η εταιρία HNE θα παρέχει στα μέλη της, κατόπιν αιτήσεώς τους, υπηρεσίες διερμηνείας και μετάφρασης που σχετίζονται με τις διοικητικές διαδικασίες. Αν χρειάζεστε μεταφραστικές υπηρεσίες, απλώς ενημερώστε τον Αντιπρόσωπο Εξυπηρέτησης Μελών στο τηλεφώνημά σας. Στη συνέχεια, κατά τη διάρκεια της κλήσης σας, με τη χρήση των υπηρεσιών της εταιρίας Language Line Services θα επικοινωνήσουμε με έναν διερμηνέα που θα μας βοηθήσει να απαντήσουμε στις ερωτήσεις σας.

(Haitian)

Kon manmb yo mande, HNE dwe bay manmb yo entèprèt ak sèvis tradiksyon pou nenpòt bagay sou fason administrasyon an fè zafè li. Si ou bezwen sèvis tradiksyon, kareman rele Reprezantan Sèvis Manmb yo lè ou rele. Epi, padan apèl ou-an, nap sèvi ak Language Line Services pou nou jwenn yon entèprèt pou ede nou reponn keksyon ou yo.

(Italian)

HNE renderà disponibili ai membri, su richiesta, servizi di interpretariato e traduzione in merito ai procedimenti amministrativi. Qualora necessitiate di tali servizi, communicate le vostre esigenze al momento della vostra chiamata ad un rappresentante del servizio membri. In questo modo, durante la chiamata, utilizzeremo il servizio Language Line Services per contattare un interprete che ci assisterà nel rispondere alle vostre domande.

(Laotian)

HNE ຈະຕ້ອງໃຫ້ບໍຣິການແກ່ສມາຊິກ, ພາຍຫຼັງມີການຂໍ, ຜູ້ແປພາສາປາກເປົ່າແລະຂຽນ ໃຫ້ການບໍຣິການທີ່ກ່ຽວ ຂ້ອງກັບຣະບຽບການຊຶ່ງເປັນບໍລິຫານ. ຖ້າທ່ານຕ້ອງການໆບໍຣິການແປພາສາ, ພຽງແຕ່ບອກກັບຜູ້ຕາງໜ້າຝ່າຍບໍຣິ ການສມາຊິກ ເວລາທ່ານໂທໄປ. ແລ້ວໃນເວລາທີ່ທ່ານໂທຢູ່ນັ້ນ, ພວກເຮົາຈະໃຊ້ສາຍບໍຣິການດ້ານແປພາສາ (Language Line Services) ໃຫ້ຕິດຕໍ່ ເອົາມາຍພາສາຜູ້ນຶ່ງ ຊຶ່ງຈະຊ່ວຍພວກເຮົາຕອບຄຳຖາມຂອງທ່ານ.

(Mandarin)

應要求，HNE 會提供會員有關行政程序方面口譯員與翻譯服務。如您須要翻譯服務，打電話來時請告知會員服務代表。然後，在與您通話中，我們會透過 Language Line Services 與口譯員連線，由他協助我們回答您的問題。

(Portuguese)

A HNE deverá fornecer aos seus associados, conforme requisição, os serviços de intérpretes e tradutores relacionados aos procedimentos administrativos. Caso necessite de serviços de tradução, mencione ao Representante dos Serviços aos Associados na ocasião da sua ligação. Assim, durante a sua chamada telefônica, utilizaremos “Language Line Services” para contatar um intérprete o qual irá nos ajudar a responder suas perguntas.

(Russian)

HNE предоставит членам, по их просьбе, услуги устного и письменного перевода, связанные с административными процедурами. Если Вам нужны услуги переводчика, скажите об этом представителю бюро обслуживания клиентов, когда Вы звоните. После этого, во время Вашего звонка, мы воспользуемся услугами Language Line Services (Бюро переводческих услуг по телефону), чтобы связаться с переводчиком, который поможет нам ответить на Ваши вопросы.

(Spanish)

HNE suministrará a los socios que así lo soliciten servicios de intérprete y traducción relacionados con los procedimientos administrativos. Si necesita servicios de traducción, solamente comuníqueselo al representante del servicio de atención a socios cuando llame por teléfono. Luego, durante su llamada, utilizaremos Language Line Services para contactarnos con el intérprete que nos ayudará a responder a sus preguntas.

Amendment to
Health New England, Inc.
Commonwealth of Massachusetts Group Insurance Commission
Member Handbook for Medicare Enrolled Retirees

This is an Amendment to your Health New England, Inc. Commonwealth of Massachusetts Group Insurance Commission Plan Member Handbook. Please keep this Amendment with your Member Handbook as it changes the terms of that Member Handbook. Any language in the Member Handbook that is inconsistent with the terms of the Amendment no longer applies. This Amendment is effective on July 1, 2006, except as noted otherwise. The Agreement is amended as follows:

BENEFIT ENHANCEMENTS		
Benefit Type	**Description**	**Effective Date**
Diabetes Education Coverage Expanded	HNE will increase the maximum number of covered visits for both individual and group diabetic education services. The limit for individual diabetic education will be increased from two visits per Calendar Year to five visits per Calendar Year. For group diabetic education, the limit will be increased from four sessions per lifetime to five sessions per Calendar Year. Members will be responsible for any applicable Copayment.	7/1/2006

BENEFIT CLARIFICATIONS		
Benefit Type	**Description**	**Effective Date**
Emergency Dental Services and Non-Dental Oral Surgery	Under the heading, ***What is not covered***, the following service is added as an exclusion: • Orthognathic surgery in conjunction with orthodontic work.	Clarification of existing benefit
Exclusions and Limitations	HNE does not cover the following items or services: • Postoperative Disposable Ambulatory Regional Anesthesia • Cold Therapy Devices	Clarification of existing benefit

PROCEDURAL CHANGES		
Benefit Type	**Description**	**Effective Date**
Change in Prior Approval Requirement Elective Inpatient Medical Admissions	HNE no longer requires Prior Authorization for In-Plan elective medical inpatient admissions. Your PCP or treating In-Plan Provider will make the arrangements for your care. He or she will coordinate any diagnostic or pre-admission work-ups. Inpatient admissions for mental health and substance abuse services still require Prior Approval by HNE.	4/1/2006

CORRECTION		
Benefit Type	**Description**	**Effective Date**
Correction to Copayment for Group Diabetic Education Services	Section 3 – Covered Benefits Detailed information on benefits for Group Diabetic Education Series • "You Pay...$15/session" is corrected to "You pay...$10/session"	Not applicable

CHANGE TO HNE'S INFERTILITY PROTOCOL		
Benefit Type	**Description**	**Effective Date**
Infertility Treatment Change in HNE's Infertility Protocol	Note: HNE has changed the Infertility Protocol referenced in the benefit description below (last paragraph in bold). Only the Protocol has changed, all other coverage provisions are the same. For copies of the updated Infertility Protocol, please contact HNE Member Services at 413-787-4004 or 800-310-2835 HNE covers all non-experimental Infertility procedures, including but not limited to: 1. Artificial Insemination (AI) 2. In Vitro Fertilization and Embryo Placement (IVF-EP) 3. Gamete Intrafallopian Transfer (GIFT) 4. Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any 5. Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor Infertility 6. Zygote Intrafallopian Transfer (ZIFT) For assisted reproductive technologies, your PCP or treating In-Plan Provider must obtain HNE's approval for the services to be covered. HNE covers these services in accordance with the terms of **HNE's Infertility Protocol**. Benefit limits and exclusions are also listed in the Protocol. You may call HNE Member Services for a copy of the protocol.	1/1/2006

PHARMACY MANAGEMENT		
Benefit Type	**Description**	**Effective Date**
Prescription Drugs Prior Approval required for certain Prescription Drugs covered under the medical benefit	The following prescription drugs require Prior Approval. They are part of the HNE medical benefit, not the HNE prescription benefit. HNE's pharmacy benefits manager has been delegated to perform prior review using HNE-approved criteria. • Cerezyme® • Fabrazyme® • Flolan® • Remodulin®	1/1/2006

PHARMACY MANAGEMENT		
Benefit Type	**Description**	**Effective Date**
Injectable Drugs Clarification of injectable drugs covered under the Prescription Drug Benefit	The following drugs are covered under HNE's Prescription Drug Benefit. The items described are subject to member Copayments for Prescription Drugs. • Growth Hormone drugs • Aranesp® • Epogen® • Procrit®	1/1/2006
Prescription Drugs Prescription drugs added to the Prior Approval List	The following items are added to the list of ***Drugs that require Prior Approval***. • Aranesp® • Epogen® • Leukine® • Procrit® • Revatio® • Ventavis® • Zorbtive®	1/1/2006
Prescription Drugs Prescription drugs added to the Prescription Drug Limitations List	The following items are added to the ***Prescription Drugs Limitations list***. HNE limits the coverage of specific drugs to control costs and ensure safe and effective use. HNE may place limits on the quantity of a drug covered, the amount that can be obtained for each Copayment, or the medical conditions for which a covered drug may be prescribed. • Arixtra® – 14-day supply per prescription fill • Fragmin® – 14-day supply per prescription fill • Innohep® – 14-day supply per prescription fill • Lovenox® – 14-day supply per prescription fill • Neulasta® – 2 syringes per 30 day period • Neupogen® – 10 vials/syringes per 30 day period • Provigil® – covered only when prescribed to treat narcolepsy or fatigue from multiple sclerosis. Not covered for any other diagnosis.	1/1/2006
Prescription Drugs Change in Copayment tiers	• The following Prescription Drugs are changing from a Tier 2 Copayment to a Tier 3 Copayment: • Beconase AQ® • Carbatrol® • Celontin® • Diastat® • Emcyt® • Gabitril® • Genotropin® • Hexalen® • Humatrope® • Innohep® • Neulasta® • Neupogen® • Nilandron® • Norditropin® • Nutropin® • Saizen® • Serostim® • Vesanoid® • Xeloda® • Zoladex® • Zorbtive®	1/1/2006

PHARMACY MANAGEMENT		
Benefit Type	**Description**	**Effective Date**
Clarification of Prior Approval Requirement: Infertility Medication	HNE requires Prior Approval for the following medications for both in-vitro fertilization (IVF) and intrauterine insemination (IUI) cycles. • Bravelle® • Cetrotide® • Fertinex® • Follistim® • Ganirelix® • Gonal F® • Luveris® • Menopur® • Repronex®	Clarification of existing benefit
Prescription Drug Limitations and Prior Approval Requirements	• Rituxan® will be covered only for the treatment of cancer and will not be covered for the treatment of rheumatoid arthritis • Nexavar® is covered for HNE members who meet the coverage criteria. There is a quantity limit of 120 tablets per 30-day period. • Revlimid® is covered for HNE members who meet the coverage criteria. Revlimid® is used to treat myelodysplastic syndrome. • Sutent® is covered for HNE members who meet the coverage criteria. Sutent® is used to treat renal cancer or GIST.	7/1/2006
Prescription Drug Tier Changes	The following prescription drugs are changing from a tier 2 copayment to a tier 3 copayment: • Yasmin 28 tablets® • Lipitor® (Lipitor® and Zocor® will move from tier 2 to tier 3 on July 1, 2006 if generic Zocor®, simvastatin, becomes available on or before that date. Otherwise, Lipitor® will change to tier 3 on the date that generic Zocor®, simvastatin, becomes available.) • Zocor® (Zocor® will move to tier 3 on the date generic Zocor®, simvastatin, becomes available.) Rapamune® has changed from a tier 3 copayment to a tier 2 copayment.	7/1/2006 or as noted
Step Therapy Program Requirement Change	The drugs listed below, used to treat cardiovascular conditions, will become Step Therapy Drugs on or after 7/1/06, pending availability of generic Zocor®. Lovastatin, pravastatin, and simvastatin are First Line drugs. • Lipitor® • Lescol® • Lescol XL® • Mevacor® • Altoprev® • Pravachol® • Crestor® • Zocor® • Caudet® • Pravigard® • Advicor®	7/1/2006

PHARMACY MANAGEMENT		
Benefit Type	**Description**	**Effective Date**
Prescription Drugs Step Therapy Program	• Members will be eligible for coverage of the Step Therapy Drug if HNE has paid a claim within the previous 180 days or there is physician documented use (excluding samples) of at least one of the First Line drugs. The use of samples does not satisfy this requirement. • Step Therapy does not apply to member who are 18 and under.	7/1/2006

THE FOLLOWING IS ADDED TO SECTION 7 – ELIGIBILITY:

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

What is a Qualified Medical Child Support Order?

A medical child support order is an order from the appropriate state court requiring a group health plan to provide coverage for a participant's child. QMCSO provisions do not define the term "child" or provide a maximum age limit. An order is qualified if it:

- Creates or recognizes the recipients' rights to receive benefits;
- Provides the name and last known mailing address of the participant and each alternate recipient;
- Provides a reasonable description of coverage;
- Provides the period covered by the order;
- Describes the plans to which the order applies;
- Does not require the plan to provide any type of benefit that is not normally available.

If a QMCSO is received by the Plan Sponsor and the order qualifies, the Plan will comply with all state medical child support laws on eligibility and enrollment, even if the Plan has more restrictive rules.

CHANGES AND ADDITIONS TO APPENDIX A:

THE FOLLOWING SECTION REPLACES "GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA" IN APPENDIX A

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

It is important that you read this notice if your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete a GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by mailing it to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2301, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at www.dol.gov/ebsa.

WHAT IS COBRA COVERAGE? COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the GIC's Health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours or employment are reduced; or
- You and your spouse divorce or legally separate.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents divorce or legally separate; or
- The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full time student, or ceases to be a full-time student).

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when

you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but you are responsible for paying for the coverage even if you do not receive a monthly statement. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. The GIC has no involvement in conversion programs, and you pay premium to the health plan for the conversion coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- You must inform the GIC of any address changes to preserve your COBRA rights;
- You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- You must make the first payment for COBRA coverage within 45 days after you elect COBRA. If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.

- You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:
- The employee's job terminates or his/her hours are reduced;
- The employee or former employee dies;
- The employee divorces or legally separates;
- The employee or employee's former spouse remarries;
- A covered child ceases to be a dependent;
- The Social Security Administration determines that the employee or a covered family member is disabled; or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

July 1 2006

THE FOLLOWING NOTICE IS ADDED TO APPENDIX A

NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

Other Permitted Uses and Disclosures: The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made on your behalf (such as appeals);
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements;
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative); when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we

have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. *You must ask for this in writing*. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. *You must ask for this by in* writing*,* along *with a reason for your request*. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. *You must ask for this in writing*. The list will *not* include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. *You must ask for this in writing*. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. *You must tell us in writing that you are in danger*, *and where to send communications.*
- Receive a separate paper copy of this notice upon request. (an electronic version of this notice is on our website at www.mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 801 or TTY for the deaf and hard of hearing at (617) 227-8583.

July 1 2006

THE FOLLOWING NOTICE IS ADDED TO APPENDIX A

IMPORTANT NOTICE
ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

The Centers for Medicare Services requires that this *NOTICE OF CREDITABLE COVERAGE* be sent to you. Please read it carefully and keep it where you can find it.

Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. This notice

- applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- provides information about your GIC-sponsored drug coverage and the new Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- explains your options; and
- tells you where to find more information to help you make a decision.

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NEW MEDICARE DRUG PLANS', SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

The New Medicare Drug Plans

The new Medicare prescription drug benefit, also known as Medicare Part D, will be offered through various health plans and other organizations. All Medicare prescription drug plans will provide at least the standard level of coverage set by Medicare; some plans might also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- **You can continue to receive prescription drug coverage through your GIC health plan rather than joining a new Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.**
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon *Senior Plan*, Harvard Pilgrim Health Care *First Seniority* or Tufts Health Plan *Medicare Preferred* (formerly *Secure Horizons*), you will lose your GIC-sponsored health plan coverage under current Medicare rules.

- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage will pay. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. After May 15, 2006, if your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1% per month for every month after May 15, 2006 that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.medicare.gov .
- Call the Group Insurance Commission at 1-617-727-2310.

Medicare part d final creditable coverage notice 05

November 2005

All other terms and conditions of this Handbook remain in full force and effect.

TABLE OF CONTENTS

SECTION 1 – INTRODUCTION

HOW TO USE THIS MEMBER HANDBOOK

This Member Handbook is for individuals who have retired from employment with the Commonwealth of Massachusetts and who are enrolled in Medicare Parts A and B. This handbook describes your benefits as a Member of Health New England, Inc. ("HNE" or "the Plan"). It tells you what health care services and supplies HNE covers and how to get them. It is set up to help you find the information you need to know quickly and easily. The Table of Contents lists each section and where it is located. At the beginning of each section is a shaded box, containing a summary of the most important things to know about that section. We have provided the detail of each bulleted item in the text below the shaded box. Certain words in this Member Handbook that begin with a capital letter have a special meaning. These words are defined in Section 16 of this Member Handbook.

If you have any questions, please call us. For your convenience, HNE's telephone numbers appear at the bottom of each page, along with our web site. Our Member Services Representatives are available Monday through Friday, from 8:00 AM to 5:00 PM.

ABOUT HEALTH NEW ENGLAND (HNE)

Health New England is a Massachusetts licensed Health Maintenance Organization (HMO). An HMO is a health plan that requires you to get your care from specific doctors, hospitals, and other health care providers that contract with the Plan. We call these providers "In-Plan Providers."

HNE In-Plan Providers are independent contractors. HNE does not control the methods In-Plan Providers use to perform their work or to provide services. To find out what hospitals, doctors, and providers are in the HNE network, please refer to your "Plan Provider Directory," call HNE Member Services, or check the HNE web site. Printed Provider Directories are updated annually and from time to time throughout the year and are available upon request. Our web site is updated weekly. Please note that In-Plan Providers may have left or joined the Plan Provider network since the time of the last update. Because providers are free to join and leave our network at any time, HNE cannot guarantee the continued participation of any specific provider or group of providers listed in our Directory. HNE's Service Area consists of the four counties of western Massachusetts (Hampden, Hampshire, Franklin, and Berkshire); part of Worcester County; as well as parts of Hartford, Litchfield, and Tolland Counties in northern Connecticut.

With HNE, your monthly premium covers a large array of medical services, including preventive care when you are healthy, and care when you are injured or sick. When you receive care from In-Plan Providers, you will not have to submit claim forms or pay bills. However, you must pay a set dollar amount for certain services, such as doctors' visits, prescriptions, and emergency room visits. This set dollar amount is called a Copayment.

Health care is covered only when Medically Necessary and appropriate. Your Primary Care Physician must provide or arrange your care, except when otherwise stated in this Member Handbook.

SECTION 2 – HOW TO OBTAIN BENEFITS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- You must choose a Primary Care Physician (PCP).
- If you need care, call your PCP.
- You do not need a referral for most In-Plan specialty care. This section describes exceptions.
- Always show your HNE ID Card when receiving services.
- In an Emergency, you may go straight to the emergency room (ER). If there is time, call your PCP first.
- If you do not follow the rules described in this Member Handbook, you may lose all or part of your coverage for that service or supply.

CHOOSING YOUR PRIMARY CARE PHYSICIAN (PCP)

Why must I choose a PCP?
Choosing a PCP is the first and most important decision you must make when you join HNE. Your PCP is the first person you should call when you need medical care. A PCP may be a doctor of internal medicine, family practice, general practice, or pediatrics. You may choose a different PCP for each member of your family. HNE's Provider Directory lists PCPs, their locations, and phone numbers. You can get a copy of our Provider Directory by calling HNE Member Services, or visit our web site.

If you choose a PCP that you have not seen before, we suggest you do the following:

- Call your PCP's office as soon as possible and tell the staff you are a new HNE Member.
- Make an appointment to see your new PCP so he or she can get to know you and begin taking care of any of your medical needs. You do not have to wait until you are sick to make this appointment. You should get to know your doctor as soon as possible.
- Ask your previous doctor(s) to send your medical records to your new PCP.

If you do not select a PCP when you enroll, we will automatically assign one to you. We will notify you in writing if your PCP stops being an In-Plan Provider. You will then need to select a new PCP. Please note that HNE does not cover services that you receive from an In-Plan PCP who is not listed by HNE as your PCP or your PCP's covering doctor.

What can I do if I am not happy with my PCP?
You can change your PCP by calling our Member Services Department. PCP changes will be effective on the next business day after your request. You may change to any PCP, unless the newly chosen doctor has notified HNE that he or she is no longer accepting new patients.

Can my PCP decide to transfer me to someone else?
Yes. Your PCP may request that you transfer to another In-Plan Doctor. HNE does not allow transfers based on the amount of medical services required by a Member or the physical condition of a Member. Your PCP must ask for HNE's approval before requesting a transfer to a new PCP. Your PCP must send you a letter requesting that you choose another PCP.

HOW TO OBTAIN MEDICAL CARE FROM AN IN-PLAN PROVIDER

How do I get medical care?
Call your PCP. It is your PCP's duty to provide or arrange most of your medical care. The services you receive must be Medically Necessary and either provided by or arranged through your PCP, except in an Emergency. Care by Out-of-Plan Providers must be approved, in advance, by HNE.

Do I need my Identification Card to receive care?
Yes. You must present your HNE ID Card to receive services. Your ID Card provides important information, such as: HNE's mailing address and telephone number; Subscriber name; Group number; benefit plan, including some Copayment amounts; identification number; as well as the name, Member number and PCP of each person covered. Having an ID Card does not guarantee you coverage for services. To receive Covered Services, you must be an HNE Member at the time you receive the service. If you permit others to use your ID Card to obtain services to which they are not entitled, your coverage may end. You should report the loss or theft of your ID Card to HNE as soon as possible. You may only use the most recent card provided to you by HNE.

What if I need Non-Emergency care after normal business hours?
At HNE, we know that medical problems may occur at any time — day or night. That is why we ask our PCPs to be on call 24 hours a day, seven days a week. You should talk to your PCP to find out about arrangements for care after normal business hours. At times, you may reach your PCP's answering service. You may also reach the doctor who is on call for your PCP. If you reach an answering service, here is what to do:

1. Say that you are an HNE Member.
2. Give your name and phone number.
3. Describe your symptoms.
4. Ask your doctor or the on-call doctor to call you back.

How do I get specialty care?
For most In-Plan specialty services, you do not need a referral. Just make your appointment, present your HNE ID card, and pay your usual Copayment. You need a referral for specialty care only when you need the following services:

- Dermatology.
- Allergy-related services from an allergist or otolaryngologist.
- Rehabilitative services of physical, occupational and speech therapy.
- Cardiac rehabilitation.

In these instances, you must get a pink HNE In-Plan Specialty Referral Form from your PCP. You should know that your PCP might want to see you before giving you a referral. Your PCP will fill out the form and then ask you to make an appointment with an In-Plan Specialist.

If you need a referral:

1. You must bring the referral to the In-Plan Specialist at the time of your visit.
2. Your PCP's referral will be good for a limited time and number of visits. When either the time or the number of visits runs out, you must get a new one.
3. Your PCP may also authorize a standing referral to an In-Plan Specialist when he or she determines that it is appropriate and the In-Plan Specialist agrees to a treatment plan for you and provides your PCP with all the necessary clinical and administrative information regularly.

Note: This procedure does not apply to mental health or substance abuse services. To find out about obtaining mental health or substance abuse services, see "How to Get Mental Health or Substance Abuse Services" later in this section.

Whether or not you need a referral, it is your responsibility to make sure that the doctor your PCP refers you to is an HNE In-Plan Doctor. If you are not sure, check the Plan Provider Directory, visit the HNE web site, or call HNE.

Can I get podiatry services from a podiatrist?

HNE does not cover routine foot care, such as care of corns, calluses, and trimming of nails, unless you are a diabetic. However, other covered podiatry services, such as the treatment of podiatric diseases and conditions, are available from an In-Plan podiatrist. For additional information, see Section 4 – Exclusions and Limitations.

What do I do if I need to go into the hospital?

For non-Emergency care, talk to your PCP or treating In-Plan Provider. If you need to be admitted to a hospital, your PCP or treating In-Plan Provider will make the necessary hospital arrangements and supervise your care. Except in Emergencies, your treating In-Plan Provider must get HNE's Prior Approval before admitting you to a hospital.

How much do I pay for services?

Some HNE services are free of charge. For most services, however, you pay a set dollar amount. This is called a Copayment. Copayments are listed in Section 3 of this Member Handbook. Please remember that, in general, you must pay any Copayments at the time you receive services. **Other than Copayments, In-Plan Providers can not bill you for Covered Services. If you get a bill from an In-Plan Provider for a Covered Service that you received, please call HNE's Member Services Department.**

Do I have to submit claims?

The only time you may have to submit claims to HNE is if you receive Covered Services from an Out-of-Plan Provider as described in the sections below. If you receive services from an Out-of-Plan Provider, please be sure to show them your HNE ID Card. Most providers will bill HNE directly. If possible, ask the Out-of-Plan Provider to submit a standard medical claim form to HNE.

If the provider will not bill HNE directly, you must send us an itemized bill that includes the diagnosis and the date of treatment. For foreign medical bills and for some providers in the U.S., you may be required to pay the provider. If you pay the bill, send proof of your payment, along with a copy of the bill, to HNE. We will reimburse you for Covered Services, less any applicable Copayments.

You must have bills for Emergency care received in a foreign country translated into English. The bill must also convert charges to U.S. dollar values as of the date of service.

HOW TO OBTAIN MEDICAL CARE FROM AN OUT-OF-PLAN PROVIDER

What if I need to receive specialty care that is not available from an In-Plan Provider?
In order to receive specialty care from an Out-of-Plan Provider, you first must have the approval of HNE. In general, most health care services can be provided by HNE In-Plan Providers. Therefore, before HNE will consider a request for you to see an Out-of-Plan Provider, you must first have your PCP refer you to an In-Plan Specialist. If there is no In-Plan Specialist available to treat you, your PCP or treating In-Plan Provider will work with HNE to identify an appropriate Out-of-Plan Provider to treat you.

To initiate this process, your PCP or treating In-Plan Provider must submit a Prior Approval Request Form to HNE. **You cannot use a pink HNE In-Plan Specialty Referral Form to obtain services from an Out-of-Plan Provider.** HNE will notify you and your doctor in writing of its decision to approve or not approve the service. If you have not received a response from HNE, you should call HNE to determine whether HNE has approved your request. You should not make an appointment with the Out-of-Plan Provider before you receive HNE's response. **Please note:** HNE does not verify the credentials of Out-of-Plan Providers; only In-Plan Providers go through HNE's credentialing process.

HOW TO OBTAIN CARE IN AN EMERGENCY

What is an Emergency?
Massachusetts law defines an "Emergency" as follows:

> An Emergency is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Stated simply, an Emergency is a medical condition that you believe will place your life or health in serious danger if you do not receive immediate medical attention. In an Emergency, go to the nearest emergency facilities, call 911, or call your local emergency number. You are always covered for care

in an Emergency. Your Primary Care Physician will arrange for any follow-up care you may need. Some problems are Emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Other problems are Emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisoning, inability to breathe, severe bleeding, loss of consciousness, and severe trauma. What all Emergencies have in common is a serious threat to health and the need for quick action.

Routine care, care that is not required immediately, or care of minor illnesses or injuries are not Emergencies. Examples of routine care or minor illnesses that are *not* Emergencies are: colds, minor sore throats, injuries of more than 24 hours' duration, or persistent or chronic illness treatable by your PCP.

All Members have the opportunity to obtain health care services for an Emergency . This includes the options of going to the nearest emergency facility, calling the local pre-hospital emergency medical service system, or dialing the emergency telephone access number (911), or its local equivalent, whenever you are confronted with an Emergency which, in the judgment of a prudent layperson, would require pre-hospital emergency services.

No Member will be discouraged in any way from using emergency facilities, local pre-hospital emergency medical service systems, or the 911 telephone number, or the local equivalent.
No Member will be denied coverage for medical and transportation expenses incurred as a result of any Emergency which meets the above conditions.

What should I do in an Emergency?
You always have coverage for care in an Emergency. You do not need a referral from your PCP. However, in all cases, if your situation allows, call your PCP first. Say that you are an HNE Member and clearly state your symptoms. Your PCP may ask you to go to an emergency room or ask you to visit a doctor's office. Your PCP or a covering doctor is on call 24 hours a day, seven days a week.
If you do not have time to call your PCP, follow these rules:

When an Emergency Occurs:

- **Seek medical care at once. Go to the nearest emergency room (ER) or dial "911". (If two hospitals are equally close, use an In-Plan Hospital listed in the Provider Directory.)**
- **Contact your PCP to notify him or her of your visit and to arrange for any follow-up care.**

If you are admitted to a hospital on an inpatient basis directly from the emergency room, you will not have to pay the emergency room Copayment.

What if I am out of the Service Area when an Emergency occurs?
If you are out of the HNE Service Area when an Emergency occurs, the guidelines listed above still apply. Call HNE Member Services to notify us of any Emergency services *not* received in a hospital emergency room (for example, at a walk-in clinic or physician's office). You should also be aware that

HNE does not cover routine care, elective surgery, or care that you could have foreseen before leaving the HNE Service Area. In addition, your PCP must coordinate your follow-up care. HNE does not cover care (including follow-up care) you receive outside the Service Area once you are medically able to return to the Service Area.

What should I do if I am in an auto accident?

If you are in an auto accident, you should follow the rules in this Member Handbook, including the rules for obtaining care in an Emergency. Remember that all follow-up care must be coordinated by your PCP and be received from an In-Plan Provider. If you are not sure if the Provider that you are being referred to is an In-Plan Provider, please check your Provider Directory, visit our web site, or call our Member Services Department.

HOW TO GET MENTAL HEALTH OR SUBSTANCE ABUSE SERVICES

How can I get mental health or substance abuse services?

To obtain treatment for mental health or substance abuse conditions, call HNE's Behavioral Health Triage Unit at 413-787-4000, ext. 5028 or 800-842-4464, ext. 5028. Your PCP or a family member may also call for you. A Behavioral Health Representative will help identify a provider for you based on your location and the nature of your concerns. The Behavioral Health Representative will refer you to an In-Plan Provider and give you a confirmation number to take with to your appointment.

SECTION 3 – COVERED BENEFITS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- To be covered, care must be Medically Necessary and appropriate; provided, referred, or arranged by your PCP; and, unless approved in advance by your PCP and HNE, provided by an In-Plan Provider.
- Some services are *not* covered.
- Many services require you to pay a Copayment at the time of service.

HNE covers the services and supplies described in this section only if they are Medically Necessary and appropriate. Your PCP must provide or arrange most of your health care following HNE policies and rules. Treatment by an Out-of-Plan Provider requires the advance written approval of both your PCP (or treating In-Plan Provider) *and* HNE. The only exceptions are the Emergency situations described in this Member Handbook.

All covered care is subject to the conditions in this Member Handbook. You should read Section 4 to learn more about care that is limited or excluded. HNE does not pay for medical care unless it is a Covered Benefit as described in this Member Handbook. HNE also does not cover medical care that is not provided and obtained as required by this Member Handbook.

CHART OF BENEFITS

The chart on the following pages is only a summary guide that we have included to assist you in locating certain benefits. The detail for each of these benefits, including any limitations or exclusions associated with the benefit, can be found on the pages referenced. You are responsible for the Copayments listed on the Chart of Benefits.

Benefit	*Copayment*	*Page*
PRESCRIPTION DRUGS (certain drugs require HNE's Prior Approval)		**12**
At an In-Plan Pharmacy (up to a 30-day supply):		12
Generic drugs	$10	
Formulary brand name drugs	$20	
Non-Formulary brand name drugs	$40	
Through Mail Order (up to a 90-day supply of maintenance medication):		12
Generic drugs	$20	
Formulary drugs	$40	
Non-Formulary drugs	$120	
INPATIENT CARE (Elective admissions require Prior Approval)		**17**
Acute Hospital Care	$0	17
Skilled Care & Inpatient Rehabilitation	$0	17
OUTPATIENT CARE		**18**
Preventive Care:		18
Routine Physical Examinations and Immunizations	$10/visit	18
Well Child Care	$10/visit	18
Eye Examinations	$10/visit	18
Hearing Tests	$10/visit	18
Annual Gynecological Exam	$10/visit	19
Mammographic Exam	$0	19
Specialist Office Visits	$10/visit	19
Diabetic-Related Items:		19
Outpatient Services • Individual Diabetic teaching visits (maximum of 2 visits per calendar year)	$10/visit	
Laboratory/Radiological Services	$0	
Durable Medical Equipment (some DME requires HNE's Prior Approval)	$0	
Group Diabetic Education Series	$10/session	20
Emergency Room Care	$50/visit	21
Diagnostic Testing:		21
In a Doctor's Office	$10/visit	
In Other Surgical Settings	$0	

Benefit	*Copayment*	*Page*
OUTPATIENT CARE (CONTINUED)		
Laboratory/Radiological Services	$0	21
Advanced Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans (requires HNE's Prior Approval)	$0	21
Outpatient Short-term Rehabilitation Services (Physical Therapy and Occupational Therapy) Day Rehabilitation Program	$10/visit/treatment type $25 for 1 day or for ½ day	21
Early Intervention Services	$10/visit	22
Outpatient Surgical Services (some services require HNE's Prior Approval):		22
In a Doctor's Office	$10/visit	
In all other settings	$0	
Second Opinions	$10/visit	22
Allergy Testing and Treatment	$10/visit	22
Allergy Injection Only	$0	
Speech, Hearing and Language Disorders	$10/visit	23
FAMILY PLANNING SERVICES AND INFERTILITY TREATMENT (some Infertility treatments require HNE's Prior Approval)		**23**
Family Planning Information, Counseling and Treatment	$10/visit	
Infertility Counseling and Treatment	$10/visit	
Laboratory Tests	$0	
Inpatient Care	$0	
Outpatient Surgery/Procedure	$0	
MATERNITY CARE		**24**
Prenatal and Postpartum Care	$0	
Delivery/ Hospital Care for Mother and Child	$0	
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (requires HNE's Prior Approval)		**26**
Mental Health Services:		26
Inpatient services	$0	
Intermediate services (such as Partial Hospitalization)	$0	
Outpatient services	$10/visit	

Benefit	*Copayment*	*Page*
Substance Abuse Services:		27
Inpatient Services	$0	
Intermediate services (such as Partial Hospitalization)	$0	
Outpatient Services	$10/visit	
DENTAL SERVICES		**28**
Inpatient Surgical Treatment of Non-Dental Conditions (requires HNE's Prior Approval)	$0	28
Emergency Dental Care:		28
In a Doctor's Office	$10/visit	
At an Emergency Room	$50/visit	
Other Covered Dental Procedures (in an outpatient surgical setting)	$0	28
OTHER SERVICES		**29**
Home Health Care (requires HNE's Prior Approval)	$0	29
Hospice Services (requires HNE's Prior Approval)	$0	30
Durable Medical and Prosthetic Equipment (some items require HNE's Prior Approval)	20% Copayment	30
Oxygen and related supplies (Covered in full, not subject to 20% DME Copayment)	$0	
Ambulance and Chair Van Services	$25/per day per Member	33
Reconstructive or Restorative Surgery	$0	33
Kidney Dialysis	$0	34
Human Organ Transplants (requires HNE's Prior Approval)	$0	34
Nutritional Support (requires HNE's Prior Approval)	$0	35
Cardiac Rehabilitation	$10/visit	36
Nurse Anesthetists and Nurse Practitioners	$10/visit	36
Scalp Hair Prostheses (Wigs)	All costs over $350	36
Coronary Artery Disease/Change of Heart Program	10% Copayment	36
Hearing Aids	See benefit description	36
Nutritional Counseling (Maximum of four visits per Calendar Year)	$10/visit	36

DETAILED INFORMATION ON BENEFITS

PRESCRIPTION DRUGS

Prescription drugs are substances that you can obtain only with the prescription of an HNE In-Plan Doctor. There are a few prescription drugs that HNE does not cover. There are also some drugs for which HNE provides limited, rather than full, coverage.

Copayments

There are three levels of Copayments (or tiers) for prescription drugs, depending on whether the drug is classified as a Generic, Formulary, or Non-Formulary drug. (These terms are defined below.) In addition, there are two ways to purchase prescribed drugs – either at an In-Plan pharmacy or through mail order. How you buy your prescribed drugs also affects how much you pay. Copayments must be paid to the pharmacy at the time of purchase.

At an In-Plan Pharmacy You Pay for up to a 30-day supply:

- **$10 per prescription or refill for Generic drugs**
- **$20 per prescription or refill for brand name Formulary drugs**
- **$40 per prescription or refill for brand name Non-Formulary drugs**

Prescription drugs filled at an In-Plan Pharmacy are limited to up to one 30-day supply per prescription. If the applicable Copayment is more than the retail price of a drug, the Member pays the retail price. Each Copayment covers up to a 30-day supply of a prescription or refill. If the prescription is for less than a 30-day supply of a medication, a full Copayment applies. Each of the Copayments listed above applies to a 30-day supply or less. The quantity of drugs in a 30-day supply is based on normal dosages. See "Prescription Drug Limitations" later in this section of the Member Handbook for further information.

HNE has a national network of participating pharmacies. To find a nearby participating pharmacy, refer to your Plan Provider Directory, call HNE Member Services at 800-310-2835 or 413-787-4004, Monday-Friday, 8a.m.-5p.m., or visit our web site.

Through Mail Order you pay for up to a 90-day supply:

- **$20 per prescription or refill for Generic drugs**
- **$40 per prescription or refill for brand name Formulary drugs**
- **$120 per prescription or refill for brand name Non-Formulary drugs (note that there is no cost advantage to obtaining a brand name Non-Formulary drug through mail order)**

You may obtain a 90-day supply of maintenance drugs through an HNE participating mail order supplier. Maintenance drugs include medications taken for a chronic illness. In general, a medication is classified as "maintenance" if it: (1) is used for chronic illnesses such as asthma, allergies, high blood pressure, etc.; and (2) has been obtained by prescription at least twice at a participating pharmacy. Each of the Copayments listed above applies to a 90-day

supply or less. The quantity of drugs in a 90-day supply is based on normal dosages. See "Prescription Drug Limitations" later in this section of the Member Handbook for further information. Please call HNE Member Services for information about how to obtain prescriptions through mail order. The following items may not be purchased through the mail service:

- Compounded medications requiring the mixing of drugs by a pharmacist.
- Any drugs for which mail service is prohibited by law.
- Prescriptions for which a 90-day supply may not be appropriate as determined by HNE.
- Narcotics.
- Injectables.
- Medications that require Prior Approval (see below for list).
- Medication with quantity limits.

Drug Classifications

HNE covers most prescription drugs and a small number of non-prescription drugs and medical supplies that are ***Medically Necessary*** for preventive care or treating illness, injury or pregnancy.

Generic and Brand/Formulary drugs comprise the HNE Formulary. If a medication is not in the HNE Formulary, it is considered Brand/Non-Formulary. Members still have access to these medications, but at higher Copayments. HNE does not waive or reduce Copayments for any prescription drugs.

Typically HNE does not add brand name medications to its list of covered drugs for at least six months after FDA approval. Once the FDA approves a drug, HNE's committee of physicians and pharmacists reviews the drug's safety, effectiveness and value. During this clinical review period, HNE does not cover the drug.

HNE also establishes exclusions and limitations on drug coverage. We rely on input from a team of doctors and pharmacists who are advised by physician consultants from numerous medical specialties. You may call HNE Member Services for the most up-to-date information about the tier status of a particular drug.

Generic: A Generic drug is a drug that is not protected by a trademark. Generic drugs contain the same active ingredients as brand name drugs and deliver the same amount of medication to the body in the same amount of time. The Food and Drug Administration (FDA) reviews Generic drugs to assure that they are safe and effective. Generic drugs are generally a much better value than brand name drugs, so a lower Copayment applies. **Note: Unless your doctor has written "no substitution" on your prescription, a Massachusetts pharmacy is required by state law to give you a Generic drug if one is available.**

Formulary: The Formulary is a list of HNE-approved ***brand name*** drugs. A committee of physicians and pharmacists considers a drug's quality, cost, safety, and performance and places drugs on the Formulary. HNE revises the Formulary from time to time. You will pay a lower Copayment for brand name drugs if they are listed in the Formulary. The Formulary is reprinted

and distributed, by mail, to all HNE clinicians each January and includes all changes made during the previous year. The Formulary is made available to all participating pharmacies. Drugs added or deleted from the Formulary during the year are communicated through HNE's Member and provider newsletters. To find out if the drug you use is in the Formulary, or to request a copy of the Formulary, call HNE Member Services or visit our web site. Please be aware that if a generic equivalent becomes available for any brand name drug on the Formulary, the brand name drug will automatically move to Non-Formulary status.

Non-Formulary: Non-Formulary drugs are also brand name drugs. However, we have found that these drugs have no special advantage over Formulary drugs that are used to treat the same condition. Non-Formulary drugs are generally more expensive than Formulary drugs. Therefore, when your doctor prescribes a Non-Formulary drug, you will pay a higher Copayment.

Changes to HNE's Formulary

HNE will provide you or your employer with 60 days prior written notice whenever a drug is moving from Formulary to Non-Formulary status. Each January, we reprint the Formulary and incorporate all changes made during the previous year. We mail the Formulary to all HNE clinicians. We communicate changes during the year through Member and provider newsletters. To find out if a drug you use is in the Formulary, or to request a copy of the Formulary, call Member Services or visit our web site.

Self-Administered Injectable Medications

Some injectable medications may be injected by properly trained medical staff only. These medications are covered in full when provided during a Covered Service. Other injectable medications are available at retail pharmacies, and may be self administered, that is, injected by the patient him- or herself. These medications are covered under HNE's pharmacy benefit even if injected by an In-Plan Provider. To find out if a self- administered injectable drug is in the Formulary, or to request a copy of the Formulary, call Member Services or visit our web site.

WHAT IS COVERED:

HNE covers the following items under the prescription drug benefit:

- Compounded medications.
- Drugs that require a prescription.
- Hormone Replacement Therapy (HRY) prescription drugs
- All birth control drugs that have been approved by the FDA.
- The following non-prescription drugs: niacin, AmLactin, and Gyne-Lotrimin.
- Off-label uses of drugs for the treatment of cancer and HIV/AIDS.
- Diabetic related medications and supplies (see page 20)
- Needles and syringes for use with covered drugs.

WHAT IS NOT COVERED:

Items that are not covered under the prescription drug benefit include, but are not limited to, the following:

- Vitamins (except prescription prenatal vitamins and prescription vitamins with fluoride).
- Experimental drugs.
- Drugs for cosmetic purposes, including, but not limited to:
    - Avage®.
    - Eldopaque Forte®.
    - Glyquin XM®.
    - Hydroquinone products.
    - Lustra®.
    - Melenex®.
    - Penlac®.
    - Propecia®.
    - Renova®.
    - Rogaine®.
    - Solage®.
    - Solaquin Forte®.
    - Tri-Luma®.
    - Vaniqa®.
- Infertility medications for donors.
- Medications for Assisted Reproductive Technology (ART) cycles/attempts without Prior Approval.
- Non-prescription drugs or medicines.
- Drugs that are not Medically Necessary and appropriate.
- Infertility Medication multi-dose kits.
- Singulair® will not be covered when prescribed to treat allergies. It will be covered only when prescribed to treat asthma.
- Xyrem®, a prescription drug.

DRUGS THAT REQUIRE HNE'S PRIOR APPROVAL:

In order for you to obtain certain drugs, your prescribing In-Plan Doctor must obtain HNE's Prior Approval. HNE's pharmacy benefit manager, Express Scripts®, performs prior review using HNE-approved criteria. If the request meets guidelines, it is approved by an Express Scripts® Prior Authorization Coordinator. If a request does not meet Prior Approval criteria, the Prior Authorization Coordinator will discuss the request with an Express Scripts® Clinical Pharmacist to resolve any questions related to Medical Necessity. HNE will provide you or your employer with 60 days prior written notice before adding any drugs to this Prior Approval list. We will provide you with an amendment that shows the change. For an updated listing of drugs that require HNE's Prior Approval, please call Member Services, or visit our web site and click on the "Pharmacy" tab. See also "Injectable Drugs" in the list of items that require Prior Approval on page 43

PRESCRIPTION DRUG LIMITATIONS:

HNE's Step Therapy Program

The Step Therapy Program is an approach to medication management. If a drug is in this program, it means there are less expensive, lower copayment drugs available to treat the same condition. For drugs in the Step Therapy Program, if the First Line drug is not effective, then HNE will cover the Step Therapy drug. All First Line drugs are therapeutically equivalent to the Step Therapy drug prescribed. This means that the US Food and Drug Administration (FDA) has approved the two drugs to treat the same conditions.

However, if it is medically necessary for you to use a Step Therapy drug before trying a First Line drug, then your doctor can contact HNE to request a medical review.

HNE will provide you or your employer with 60 days prior written notice before adding any drugs to this list of Step Therapy drugs. We will provide you with an amendment that shows the change. For an updated listing of Step Therapy drugs, please call Member Services, or visit our web site and click on the "Pharmacy" tab,

HNE's Quality through Quantity Management Program

All prescription medications in the United States are approved by the Food and Drug Administration (FDA) with specific recommendations and limitations associated with dosage. HNE's Quality Management Program can help you to ensure that you receive the correct medication and dose that will be effective for you. When a prescription is filled, it is electronically screened for several quality issues, including allergies, drug-drug interactions and dosage limits.

For example, the screening might show that you are taking more pills than you need. If you are taking two pills of one medication, such as a 10 mg pill, then the pharmacist may be able to dispense 20 mg pills to you so that you can take only one 20 mg pill at a time. When you fill your prescription, you would be taking the same total dosage each time, but taking it in one pill instead of two.

Sometimes a pharmacist may notice that your prescription quantity for the month exceeds the monthly limit recommended by the FDA or an accepted clinical practice guideline. In this case you and your provider will be informed. This allows an opportunity for your doctor to decide if your dosage should be maintained at the current level or if you might be eligible to adjust to a dose within the FDA recommendations.

In all cases, your provider may submit information for medical case review to allow your prescription to be processed outside of these guidelines. You can be assured that we will work with you and your physician to be certain that you always get the correct medication in the simplest and safest form for you.

In addition, HNE may place limits on the quantity of a drug covered, the amount that can be obtained for each Copayment, or the medical conditions for which a covered drug may be prescribed.

HNE will provide you or your employer with 60 days prior written notice before limiting coverage of any other drugs. We will provide you with an amendment that shows the change. For an updated listing, of drug specific quantity limitations, please call Member Services, or visit our web site and click on the "Pharmacy" tab,

INPATIENT CARE

In order to receive elective inpatient hospital care, a Member must get HNE's Prior Approval. Your PCP or treating In-Plan Provider will make the arrangements for your care. He or she will coordinate any diagnostic or pre-admission work-ups.

A. Acute Hospital Care (Elective admissions require HNE's Prior Approval): **You Pay… $0**

HNE covers acute hospital care to the extent Medically Necessary. There is no limit per Calendar Year on the number of days covered.

B. Skilled Care and Inpatient Rehabilitation (Requires HNE's Prior Approval): **You Pay… $0**

HNE covers non-Custodial Care in a facility licensed to provide skilled nursing or rehabilitative care on an inpatient basis. . (For a definition of Custodial Care, see Section 16 – Definitions.) HNE covers up to a total of 100 days per Calendar Year only when you need daily skilled care or rehabilitative services that must be provided in an inpatient setting. All skilled care and inpatient rehabilitation is subject to HNE's Prior Approval and ongoing medical review for medical necessity.

WHAT IS COVERED:

Admission into any inpatient facility includes, but is not limited to, the following services:

- Semi-private room and board.
- Private room (when Medically Necessary and ordered by a doctor).
- Physician and surgeon services.
- General nursing services.
- Laboratory and pathology services.
- Intensive care.
- Coronary care
- Dialysis services.
- Short-term rehabilitation services.

WHAT IS NOT COVERED:

Items or services that are not covered under the inpatient care benefit include, but are not limited to, the following:

- Personal or comfort items, including telephone and television charges, during hospitalization or as an outpatient

- Rest or Custodial Care or long-term care
- Blood or blood products, including the cost of donating and storing blood for use during surgery or other medical procedure
- Charges after the date on which your membership ends
- Unskilled nursing home care
- Any additional charges incurred for a patient who remains in the hospital for his/her convenience beyond the discharge hour

OUTPATIENT CARE

HNE covers outpatient care that you receive from your PCP at a doctor's office or in a hospital. HNE also covers care that you receive upon referral from your PCP to an HNE In-Plan Provider. The only times your PCP does not need to provide or arrange your care is in an Emergency or for specialty services that do not require a referral.

A. Preventive Care:

HNE covers preventive care according to your individual medical needs. Your PCP generally provides these services.

1. Routine Physical Examinations and Immunizations **You Pay… $10 per visit**

HNE covers preventive periodic health exams and immunizations for adults and children over age 6. The frequency of covered preventive exams depends on the age and health status of the Member.

2. Well Child Care **You Pay… $10 per visit**

HNE covers well child care for children from birth until age 6. HNE covers physical examination, history, measurements, sensory screening, and developmental screening and assessment at the following intervals: six times during the child's first year after birth; three times during the next year; and then, annually until age 6.

HNE covers hereditary and metabolic screening at birth; appropriate immunizations; tuberculin tests; hematocrit, hemoglobin, or other appropriate blood tests; and urinalysis as recommended by the In-Plan Doctor. HNE covers lead screening in accordance with Massachusetts law. HNE also covers necessary care and treatment of medically diagnosed congenital birth defects and birth abnormalities or premature birth.

3. Eye Examinations **You Pay… $10 per visit**

HNE covers one routine eye examination each Calendar Year. You may schedule your exam by calling an In-Plan optometrist or ophthalmologist. *As with most other specialty services, no referral is required.*

4. Hearing Tests **You Pay… $10 per visit**

HNE covers hearing tests when Medically Necessary.

5. Annual Gynecological Exam **You Pay… $10 per visit**

HNE covers one routine gynecological exam per Calendar Year. Coverage includes a Pap smear (cytological screening) and pelvic exam. In addition, HNE covers any subsequent obstetric or GYN services determined by that provider to be Medically Necessary because of such exam. (You may schedule your exam by calling an In-Plan OB/GYN.) *You do not need a referral.*

6. Mammographic Exams **You Pay… $0**

HNE covers mammographic exams as follows:

- One baseline mammogram for women who are between the ages of 35 and 40.
- On an annual basis for women 40 years of age and older.
- Otherwise, when Medically Necessary and appropriate.

WHAT IS NOT COVERED:

Services that are not covered under the outpatient care benefit include, but are not limited to, the following:

- Services that a third party or court order requires. For example, employment, school, sports, pre-marital, and summer camp examinations are not covered.
- Services associated with hiring requirements.

B. Specialist Office Visits: **You Pay… $10 per visit**

You must get a pink HNE In-Plan Specialty Referral from your PCP for the following services:

- Dermatology.
- Allergy-related services from an allergist or otolaryngologist.
- Rehabilitative services of physical, occupational and speech therapy.
- Cardiac rehabilitation.

See "How do I get specialty care?" in Section 2.

Obstetric/Gynecology services – All female Members may receive the services listed below from an obstetrician, gynecologist, certified nurse midwife, or family practitioner without a referral:

- Annual preventive GYN health exams, including any subsequent obstetric or GYN services determined by that provider to be Medically Necessary because of such exam.
- Maternity care.
- Medically Necessary evaluations and health care services for GYN conditions.

You may schedule these visits yourself. Normal Copayment rules apply to these visits. (See also Preventive Care, Maternity Care

C. Diabetic-Related Items:

HNE covers the following items and services when they are prescribed by an In-Plan Provider and are Medically Necessary for the diagnosis or treatment of insulin-dependent, insulin-using, gestational, and non-insulin-dependent diabetes:

1. Outpatient services **You pay… $10 per visit**

HNE covers outpatient diabetes self-management training and education, including medical nutrition therapy and nutritional counseling. HNE covers Individual Diabetic teaching visits up to a maximum of 2 per calendar year.

2. Laboratory/radiological services **You pay… $0**

HNE covers laboratory tests including glycosylated hemoglobin, HbAlc tests, urinary protein/microalbumin, and lipid profiles.

3. Durable medical equipment (DME) **You pay…$0**

HNE covers the following durable medical equipment for diabetics:

- Blood glucose monitors.
- Voice synthesizers for blood glucose monitors for use by the legally blind.
- Visual magnifying aids for use by the legally blind.
- Insulin pumps and insulin pump supplies (*requires HNE's Prior Approval*).
- Therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease. The need for therapeutic shoes and shoe inserts must be certified by the treating doctor, prescribed by an In-Plan podiatrist or other qualified doctor, and furnished by a podiatrist, orthotist, prosthetist, or pedorthist (*requires HNE's Prior Approval*).

4. Prescription drugs **You pay… applicable prescription drug Copayment**

HNE covers the following items under the prescription drug benefit. See the prescription drug benefit for information about Copayment amounts.

- Blood glucose monitoring strips, urine glucose strips, and ketone strips.
- Lancets.
- Insulin, insulin pens, and insulin syringes.
- Prescribed oral diabetes medications that influence blood sugar levels.

5. Group Diabetic Education Series **You pay… $15/session**

HNE covers a four-session series of Group Diabetic Education services. This is a specific education program targeted at individuals with either newly diagnosed diabetes or uncontrolled diabetes. A Registered Nurse certified in diabetes education and a Registered Dietitian teach these services. Participants learn self-management techniques, as well as information about medical testing, prescription medication and insulin.

HNE covers one four-session series per lifetime. These services are covered in addition to the two individual sessions per calendar year currently covered by HNE.

D. Emergency Room Care: **You Pay… $50 per visit (waived if admitted directly from ER)**

See Section 2 for information about how to obtain care in an Emergency. If you need follow-up care after you are treated in an emergency room, you must call your PCP. He or she will provide or arrange for the care you need.

WHAT IS NOT COVERED:

Services that are not covered under the emergency room care benefit include, but are not limited to, the following:

- Follow-up care, unless provided or arranged by your PCP.
- Non-Emergency care provided in an emergency room.
- Care that you could have foreseen before leaving the HNE Service Area.
- Care from an Out-of-Plan Provider once you are medically able to return to the Service Area.

E. Diagnostic Testing: **You Pay…$10 in a doctor's office**
$0 in other surgical settings

HNE covers outpatient diagnostic testing to diagnose illness, injury, or pregnancy.

F. Laboratory and Radiological Services: **You Pay… $0**

HNE covers laboratory testing and radiological services when performed in a doctor's office or other lab facility. These services include, but are not limited to: x-rays, ultrasound, and mammography.

G. Advanced Diagnostic Imaging (Requires HNE's Prior Approval) **You Pay… $0**

In order to be covered, the following advanced diagnostic imaging procedures require Prior Approval: Computerized Tomography (CT) scans; Positron Emission Tomography (PET) scans; Magnetic Resonance Imaging (MRI); and Magnetic Resonance Angiograms (MRA).

H. Outpatient Short-term Rehabilitation Services:
You Pay…$10 per visit per treatment type

Short-term rehabilitation services include physical, occupational, and respiratory therapy. HNE only covers short-term therapy for rehabilitation. This benefit is limited to 90 days per acute episode, per Calendar Year for physical, occupational and respiratory therapy; there is no limit for speech therapy. *(See page 23 for a description of speech therapy coverage.)* The benefit is unlimited when provided as part of a home health care plan. There must be objective, measurable improvements in your medical or clinical condition during the course of the therapy for coverage to continue.

Day Rehabilitation Services. You pay … $25 for one full day or for one half day. This includes full or half day programs with more than one treatment type: including physical, occupational, and speech therapy. HNE covers a maximum of 15 days of Day Rehabilitation services per condition per lifetime. Half day sessions count as one day.

HNE does not cover rehabilitative treatment for non-acute chronic conditions. Chronic conditions are those that exist for an extended time or continue past the expected recovery time for acute or short-term conditions. For example, HNE defines chronic pain as pain continuing more than three months after the injury or illness causing the original pain. HNE covers treatment for acute episodes of an illness related to your chronic condition.

HNE does not cover maintenance treatment. Maintenance treatment is designed to retain health or bodily function, to continue your current state or condition, or to monitor your current state or condition. HNE only covers therapy that will lead to significant measurable improvement in your condition and not just temporary improvement or relief of symptoms.

WHAT IS NOT COVERED:

Services that are not covered under the outpatient short-term rehabilitation benefit include, but are not limited to, the following:

- Massage therapy, including myotherapy.

H. Early Intervention Services: **You Pay… $10 per visit**

Covered Services consist of Medically Necessary early intervention services delivered by certified early intervention specialists who are working in early intervention programs certified by the Department of Public Health. Coverage is provided for Members from birth until age 3. Benefits are limited to $5,200 per child per Calendar Year, with a lifetime maximum of $15,600 per child.

I. Outpatient Surgical Services: **You Pay… $10 in a doctor's office**
$0 in a hospital

HNE covers outpatient or ambulatory surgery, including related services. In addition, HNE covers certain procedures, such as sigmoidoscopies, endoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies under the outpatient surgical services benefit. *Certain outpatient surgical services require Prior Approval by HNE.* Examples include, but are not limited to, the following: laser-assisted uvulopalatoplasty or uvulopalatopharyngoplasty (corrective surgery of the palate, uvula, or related structures); oral surgery for treatment of non-dental conditions; reduction mammoplasty; and rhinoplasty;. HNE will only approve these services if they are Medically Necessary Covered Services and meet HNE's clinical review criteria.

J. Second Opinions: **You Pay… $10 per visit**

HNE covers second opinions from an In-Plan Provider.

K. Allergy Testing and Treatment: **You Pay… $10 per visit**
$0 Copayment for Allergy Injection Only

HNE covers testing, antigens, and allergy treatments.

L. Speech, Hearing and Language Disorders: **You Pay… $10 per visit**

This plan covers Medically Necessary diagnosis and treatment of speech, hearing and language disorders. HNE does not cover these services when available in a school-based setting.

FAMILY PLANNING SERVICES AND INFERTILITY TREATMENT

You Pay…

- **$10 per visit for outpatient care, except as otherwise listed.**
- **$0 for laboratory tests.**
- **$0 for inpatient care.**
- **$0 for outpatient surgery.**

A. Family Planning Services

HNE covers family planning services when provided by your PCP or an In-Plan OB/GYN Provider. This includes pregnancy testing and genetic counseling. *Services obtained from an In-Plan OB/GYN Provider do not require a referral.*

WHAT IS COVERED:

HNE covers the following services under the family planning benefit:

- Counseling and diagnostic services for genetic problems and birth defects.
- Family planning information and consultation.
- Pregnancy testing.
- Sterilizations.
- Voluntary termination of pregnancy.
- Physician office visits related to the Member's use of contraceptive drugs or devices.
- Services related to fitting a diaphragm or administering Depo-Provera.
- Intrauterine Devices (IUD's) and their insertion and removal.

WHAT IS NOT COVERED:

- Reversal of voluntary sterilization.

B. Infertility Treatment (some services require HNE's Prior Approval):

HNE does not require your PCP to submit a referral for the initial consultation and evaluation for infertility. *For Assisted Reproductive Technologies, your PCP or treating In-Plan Provider must obtain HNE's approval for the services to be covered.* HNE covers these services in accordance with the terms of HNE's Infertility Protocol. Benefit limits and exclusions are also listed in the Protocol. You may call HNE Member Services for a copy of the Protocol.

WHAT IS COVERED:

HNE covers all non-experimental Infertility procedures, including but not limited to::

- Consultation and evaluation.
- Laboratory tests.
- Artificial insemination.

- Intrauterine insemination (IUI).
- Assisted Reproductive Technologies, including, but not limited to:
  - in-vitro fertilization and embryo placement (IVF-EP).
  - gamete intrafallopian transfer (GIFT).
  - zygote intrafallopian transfer (ZIFT).
  - intra-cytoplasmic sperm injection (ICSI) for the treatment of male factor Infertility.

  (All requests for Assisted Reproductive Technologies require Prior Approval.)
- Sperm, egg and/or inseminated egg procurement, processing, and banking when associated with an approved active cycle, to the extent such costs are not covered by the donor's insurer.

WHAT IS NOT COVERED:

Services that are not covered under the Infertility benefit include, but are not limited to, the following:

- Any Infertility services, including consultations, testing and procedures, if either the Member or their spouse has previously undergone a voluntary sterilization or its reversal.
- Infertility treatment for Members who are not medically infertile.
- Any costs associated with any form of surrogacy, including gestational carriers.
- Non-mandated Infertility treatments.
- Cryopreservation of eggs.
- Procedures associated with gender selection, convenience, or genetic engineering.
- Early diagnosis of genetic or chromosomal abnormalities.
- Donation or sale of gametes or embryos.
- Clinical or laboratory research.
- Any fees to a donor or program for donation of sperm/egg(s).
- Infertility medications for donors.
- Medications for ART cycles/attempts without Prior Approval.
- Assisted hatching.

MATERNITY CARE

You Pay… $0 per admission

You do not need a referral for prenatal care. However, you do need to get this care from an In-Plan Provider. An In-Plan Provider must make all arrangements for inpatient care.

Important Notice of Rights

Massachusetts law (M.G.L. c.175, *§* 47F) gives you the right to stay in the hospital with your baby for at least 48 hours after giving birth (or 96 hours after birth if you have a cesarean section). If this time period ends between 8:00 PM and 8:00 AM, you have the right to stay in the hospital until after 8:00 AM, unless you want to leave earlier. If you would like to go home from the hospital early (before 48 hours after giving birth or 96 hours after a cesarean section), you may do so. If you choose to leave early, HNE covers one home visit to check you and your new baby. This home visit must occur within 48 hours after you go home. HNE may cover more than one home visit if it is Medically Necessary. Any decision to go home early is made by the attending provider in consultation with the mother. The term attending provider includes the obstetrician, pediatrician, or certified nurse midwife attending the mother and newly born child.

If you have any questions about your rights under this law, talk to your doctor or nurse, or call the Department of Public Health at 800-436-7757.

If you feel your rights have been denied under this law, you may file an appeal with the Department of Public Health at 800-436-7757. TDD/TTY 800-439-2370. Filing an appeal will prevent you from being discharged while the appeal is being considered.

WHAT IS COVERED:

HNE covers the following services under the maternity care benefit:

- Prenatal and postpartum care, including outpatient lactation consultation and parent education.
- Diagnostic tests.
- Delivery.
- Routine nursery charges (This includes common services given to a healthy newborn. For continued coverage of your child, you must enroll your child as a Member within 31 days of the date of birth.).
- Newborn hearing screening.
- One home visit if you choose to leave the hospital early and more than one visit if Medically Necessary.

WHAT IS NOT COVERED:

Services that are not covered under the maternity benefit include, but are not limited to, the following:

- Routine maternity (prenatal and postpartum) care when you are traveling outside the HNE Service Area.
- Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery.
- Home deliveries.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

All mental health and substance abuse services must be approved in advance by Health New England. To obtain treatment for mental health or substance abuse, call HNE's Behavioral Health Triage Unit at 413-787-4000, ext. 5028 or 800-842-4464, ext 5028. Your PCP or a family member may also call for you. A Behavioral Health Representative will help identify a provider for you based on location and the nature of your concerns. The representative will refer you to an In-Plan Provider and give you a confirmation number to take to your appointment.

A. Mental Health Services:

Psychiatrists, psychologists, licensed independent clinical social workers, mental health counselors, or clinical specialists in psychiatric and mental health nursing may provide mental health services. HNE will only cover mental health services when they are Medically Necessary.

HNE will provide coverage as follows:

1. In-hospital care (no limit): You Pay… $0

Covered alternatives to hospitalization include intensive outpatient visits, partial hospitalization programs, and emergency respite programs.

2. Outpatient care (no limit): You Pay… $10 per visit

Biologically based mental disorders

HNE will cover the following biologically based mental disorders, as these disorders are described in the most recent edition of the diagnostic and statistical manual of the American Psychiatric Association (DSM):

- Schizophrenia.
- Schizoaffective disorder.
- Major depressive disorder.
- Bipolar disorder.
- Paranoia and other psychotic disorders.
- Obsessive-compulsive disorder.
- Panic disorder.
- Delirium and dementia.
- Affective disorders.
- Any biologically based mental disorders appearing in the DSM that are scientifically recognized and approved by the Commissioner of Mental Health in consultation with the Commissioner of the Division of Insurance.

Rape-related mental health treatment

HNE will provide coverage for the diagnosis and treatment of rape-related mental or emotional disorders for victims of a rape or victims of an assault with the intent to commit rape.

Services for children and adolescents under the age of 19

HNE will cover non-biologically based mental, behavioral, or emotional disorders described in the DSM that substantially interfere with or substantially limit the functioning and social interactions of children and adolescents under age 19. The interference or limitation must be documented and referred for treatment by the PCP, primary pediatrician, or a licensed mental health professional, or be evidenced by conduct including, for example:

- An inability to attend school as a result of the disorder.
- The need to hospitalize the child or adolescent as a result of the disorder.
- A pattern of conduct or behavior caused by the disorder that poses serious danger to self or others.

Benefits for ongoing treatment will continue beyond the adolescent's 19th birthday until the course of treatment is completed if the adolescent remains covered under his or her parent's plan as a Student Dependent or Disabled Dependent or if the adolescent elects to pay for continuation coverage.

All other mental disorders

HNE will cover all other mental disorders described in the most recent edition of DSM.

Psychopharmacological services and neuropsychological assessment services

HNE covers these services to the same extent as all other medical services.

B. Substance Abuse Services:

HNE will provide coverage for the diagnosis and treatment of substance abuse. To obtain this coverage, a Member is only required to call HNE's Behavioral Health Triage Unit and provide their name, the type of services they are requesting, the reason they require these services, and when they will be receiving the services. HNE covers these services as follows:

1. Inpatient Services

- Drug or Alcohol Rehabilitation : **You Pay… $0**

Covered alternatives to hospitalization include crisis outpatient visits, day and evening partial hospitalization programs, and emergency respite programs.

HNE covers inpatient detoxification as long as it is Medically Necessary.

2. Outpatient Services

HNE covers outpatient services including services provided by a physician or psychotherapist who devotes a substantial portion of his or her time to treating drug addicted and intoxicated persons or alcoholics.

- Drug or Alcohol Rehabilitation: **You Pay… $10 per visit**

DENTAL SERVICES

You Pay…

- **$10 per visit in a doctor's office**
- **$0 per outpatient surgical treatment**
- **$50 per visit at an emergency room**
- **$0 per inpatient surgical treatment**

HNE covers only the limited dental services described below No other dental services are covered.

A. Surgical Treatment of Non-Dental Conditions of the Oral Cavity (Requires HNE's Prior Approval):

This benefit addresses surgical treatment of non-dental conditions, such as lesions, cysts, tumors of the jaw and gums, reduction of a dislocated or fractured jaw or facial bone, and diseases of the mouth.

B. Emergency Dental Care:

HNE covers the initial Emergency dental care needed due to a traumatic injury to sound, natural teeth. You must receive all services, except for suture removal, within 72 hours of injury. Coverage is limited to initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays. HNE does not cover follow-up care or restorative treatment. You must report Emergency dental care to HNE if *not* received in a hospital emergency room (for example, at a walk-in clinic or physician's office).

C. Dental Procedures:

HNE covers the following procedures only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely:

- Extraction of seven or more teeth.
- Gingivectomies (including osseous surgery) of two or more gum quadrants.
- Excision of radicular cysts involving the roots of three or more teeth.
- Removal of one or more impacted teeth.

Serious medical conditions include, but are not limited to, hemophilia and heart disease. *Your PCP must authorize, and request Prior Approval for, all inpatient and surgical day care admissions.*

WHAT IS COVERED:

HNE covers the following services under the dental benefit:

- Extraction of teeth when needed to avoid infection of teeth damaged in an injury.
- One follow-up visit if treatment results in extraction of teeth.
- Suturing and suture removal.
- Reimplanting, repositioning and stabilization of dislodged or partly dislodged natural teeth.
- Medication received from the provider.

WHAT IS NOT COVERED:

Services that are not covered under the dental benefit include, but are not limited to, the following:

- Fillings, crowns, implants, caps, or bridges.
- Braces.
- Root canals.
- Dentures.
- Periodontics and orthodontics.
- Dental treatment of temporomandibular joint syndrome (TMJ). Dental treatment of TMJ is defined as conservative, nonsurgical intervention. This may include, but is not limited to: therapeutic splints, oral appliances, or corrective dental treatments (for example, crowns, bridges, braces and prosthetic appliances).
- Removal of impacted teeth to prepare for or support orthodontic, prosthodontic, or periodontal procedures.
- Removal of non-impacted wisdom teeth.

OTHER SERVICES

A. Home Health Care (Requires HNE's Prior Approval): **You Pay… $0**

HNE only covers Medically Necessary home health care services provided in conjunction with a physician-approved home health services plan. A licensed home health agency must provide the services. Care must be provided in the Member's home. (A hospital, skilled nursing, or rehabilitation facility is not considered to be the home.) The home must also be the best place to get Covered Services. Your PCP must arrange all home health care. HNE must approve the appropriateness and Medical Necessity of home health care before services begin. HNE will regularly review these factors.

WHAT IS COVERED:

HNE covers the following only if they are Medically Necessary:

- Physical, occupational, and speech therapy (the visit limit described in Outpatient Care/Short-term Rehabilitation does not apply when provided as part of the home health benefit).
- Skilled nursing services provided by licensed professionals.
- Durable medical equipment and supplies.
- Medical social services.
- Nutritional counseling.

- Services of a home health aide.

WHAT IS NOT COVERED:

Services that are not covered under the home health benefit include, but are not limited to, the following:

- Disposable supplies such as bandages.
- Custodial Care, unskilled home health care, and homemaking, whether at home or in a facility setting.
- Private duty or block nursing and personal care attendants.
- Long-term care.

B. Hospice Services (Requires HNE's Prior Approval): **You Pay… $0**

HNE covers hospice services provided by a hospice provider for terminally ill Members with a life expectancy of six months or less. Members can continue to receive hospice care for as long as they are certified by their doctor and the hospice director as terminally ill and having a life expectancy of six months or less. After the first six months HNE will request documentation of continued certification. Care may be provided at home or on an inpatient basis. HNE will only cover inpatient care when skilled nursing care is Medically Necessary. Covered Services include, but are not limited to: physician services, nursing care, social services, volunteer services, and counseling services.

C. Durable Medical and Prosthetic Equipment (some items require HNE's Prior Approval):

You Pay… 20% Copayment

Please call Member Services with questions about whether a particular item is covered.

HNE will provide coverage for certain durable medical equipment (DME) and prosthetic devices. These items must be prescribed by a physician and be Medically Necessary.

In order to be covered, durable medical equipment must meet the following criteria:

1. It is primarily and customarily used in the treatment of an illness or injury or for the rehabilitation of a malformed body part. (This does not apply to prostheses.)
2. It is able to withstand repeated use.
3. It is primarily intended for activities of daily living. It is not intended primarily for sports-related purposes.
4. It is not intended primarily for sports-related purposes.
5. It is appropriate for home use (i.e., not hospital or physician equipment).
6. It should not serve the same purpose as equipment already available to the Member. (An exception may be made if the equipment contributes to important clinical decisions and will supply the level of precision needed.)
7. It should not be more costly than a medically appropriate alternative.

HNE will only cover one item of each type of equipment that meets the Member's need. No back-up items are covered.

WHAT IS COVERED

- HNE covers DME, prosthetic devices, and some medical and surgical supplies when Medically Necessary. For each covered item, the Member is responsible for 20% of the total cost of the item. The total cost of the item is the cost of the equipment to HNE. HNE may decide whether to purchase or rent the equipment. HNE may recover the equipment if your doctor decides you no longer need it, or if your membership ends. The cost of the repair and maintenance of covered equipment is also covered.
- HNE covers Oxygen and related services. These services are covered in full, and the 20% Member responsibility does not apply.

  HNE Covers items such as those listed below:

  - Canes/Crutches/Walkers
  - Certain types of braces or splints
  - Hospital beds
  - Infusion pumps
  - Wheelchairs
  - Ostomy supplies
  - Certain wound care supplies
  - Certain diabetic equipment and supplies (see page 20)
  - Respiratory equipment and related supplies
  - Limb prostheses (artificial arms and legs), other than electronic or myoelectric devices
  - Breast prostheses (related to mastectomy as required by law)
  - Compression stockings
  - Oxygen and related supplies (not subject to dollar limit)

What requires Prior Approval

- Certain diabetic equipment and supplies (see page 20)
- Facial Prostheses (including artificial eyes)
- Power wheelchairs
- Specialized beds/mattresses for wound care
- Specialized helmets for medical disorders
- High cost equipment, including:
  - Air fluidized beds
  - Bone Growth Stimulators
  - Cochlear Implants
  - External defibrillators
  - High-frequency chest wall compression devices/oscillation vests
  - Intrapulmonary percussive ventilation systems
  - Sacral nerve stimulators
  - Spinal cord stimulators

- Wound vacuum systems

WHAT IS NOT COVERED

- Arch supports, orthotic devices and corrective shoes (except those for diabetic foot care)
- Articles of special clothing, mattress and pillow covers, including hypo-allergenic versions
- Bed pans and bed rails
- Bidets; bath/shower chairs
- Certain disposable items or dressing supplies (for example, alcohol wipes, sterile water, saline solution, tape, Band-Aids, adhesive remover, topical anesthetics)
- Comfort or convenience items such as telephone arms, air conditioners, and overbed tables
- Dehumidifiers, humidifiers, air cleaners or purifiers, HEPA filters and other filters, and portable nebulizers
- Electric and myoelectric artificial limbs
- Elevators, ramps, stair lifts, chair lifts, strollers, and scooters
- Exercise or sports equipment
- Eyeglasses and contact lenses (unless specifically covered in your Member Handbook)
- Heating pads, hot water bottles, and paraffin bath units
- Home blood pressure monitors and cuffs
- Hot tubs, saunas, Jacuzzis, swimming pools, or whirlpools
- Incontinence products
- Safety equipment (for example, car seats, or safety belts, harnesses or vests)
- Speech generating devices and external urinary catheters
- Any home adaptations, including, but not limited to home improvement and home adaptation equipment
- Repair or replacement of equipment or devices as a result of loss, negligence, willful damage, or theft
- Items that are considered experimental, investigational, or not generally accepted in the medical community
- Items not listed or listed as “not covered” on the DME and medical and surgical supplies list.
- Items that do not meet the coverage criteria listed above

HNE will notify you of any change to the list of what is covered, requires Prior Approval, or is not covered. HNE will provide you with an amendment to this Member Handbook, which shows the change.

D. Ambulance Transport: **You Pay… $25 per day per Member**

Member is responsible for one Copayment per day. HNE covers ambulance and chair van services as follows:

- **Emergency Transportation** - HNE covers transportation in a medical Emergency (i.e., where a prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm). HNE covers transportation services from the place where a person is injured or stricken by disease to the nearest hospital where treatment can be given. HNE will also cover transport from one hospital to another hospital when the first hospital does not have the required services and/or facilities to treat the Member.
- **Air Ambulance** - HNE covers air ambulance services in the case of a life threatening Emergency or when otherwise pre-authorized by HNE.
- **Non-Emergency Transportation (requires Prior Approval)**- HNE covers ambulance or chair van services for a Member from a hospital setting to their home, or to a skilled nursing facility, if the Member cannot be safely or adequately transferred without endangering their health. All non-emergency transportation services must be pre-approved by HNE.

WHAT IS NOT COVERED

- HNE does not cover transportation by ambulance or by chair van for patient convenience or for non-clinical reasons.
- HNE does not cover transportation to or from a doctor's office, clinic, or other place for medical care that can be planned ahead of time.

E. Reconstructive or Restorative Surgery: **You Pay… $0**

HNE covers reconstructive surgery to repair, improve, restore or correct bodily function caused by an accidental injury, congenital anomaly or a previous surgical procedure or disease.

HNE will provide coverage, following a mastectomy, for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses (subject to the 20% coinsurance for DME and prosthetics).
- Any physical complications resulting from the mastectomy, including lymphedemas.

Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

The Plan will not cover reconstructive or restorative surgery for dental procedures, procedures for cosmetic purposes only or treatment for complications resulting from non-covered cosmetic procedures.

F. ***Kidney Dialysis:*** **You Pay… $0**

HNE covers kidney dialysis on an inpatient or outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary payer for dialysis. You must also pay any Medicare premium.

WHAT IS NOT COVERED:

The following are not covered under the kidney dialysis benefit:

- Charges to acquire power, water, and sanitary waste disposal systems for attaching a dialyzer or home hemodialysis.
- The cost of electricity or water used in the dialysis procedure.
- Compensation for anyone in assisting in the dialysis procedure.
- Expenses incurred in the installation of a dialyzer or deionizer which are not essential to its operation or installation.

G. ***Human Organ Transplants (Requires HNE's Prior Approval):*** **You Pay… $0**

WHAT IS COVERED:

HNE covers the following organ transplants when Medically Necessary:

- Autologous bone marrow transplants for the following diagnoses:
  - acute leukemia in remission;
  - resistant non-Hodgkin's lymphomas;
  - advanced Hodgkin's disease;
  - recurrent or refractory neuroblastoma.
- Allogeneic or autologous bone marrow transplants for multiple myeloma, aplastic anemia, leukemia, severe combined immunodeficiency disease, Wiskott-Aldrich Syndrome, and cases of metastatic breast cancer which meet the coverage eligibility requirements established by the Massachusetts Department of Public Health. HNE does not cover bone marrow or stem-cell harvest or rescue and related treatments, except for these diseases.
- Cornea transplant. Contact lenses following a cornea transplant are covered for up to one year, if Medically Necessary.
- Heart transplant.
- Heart/lung transplant.
- Lung transplant.
- Kidney transplant.
- Liver transplant.
- Human leukocyte antigen testing or histocompatibility testing for a Member when necessary to establish such Member's bone marrow transplant donor suitability. HNE covers the costs of testing for A, B, or DR antigens, or any combination thereof.

In the case of bone marrow transplants, if a covered bone marrow transplant is not available from an In-Plan Provider, HNE will pay for services rendered by an Out-of-Plan Provider. You must get Prior Approval before receiving services from an Out-of-Plan Provider. In the case of covered human organ transplants, where the Member is the recipient of a human

organ, HNE covers the services for the donor *only* when HNE has proof that the services are not covered under any other health insurance contract. When an HNE Member is the donor, HNE covers services for this Member only if the recipient's health plan will not cover the services.

WHAT IS NOT COVERED:

The following are not covered under the transplant benefit:

- Human organ transplants that are not listed above or that are experimental or unproven.
- Transportation and lodging expenses for a Member and/or his or her family.
- Artificial or animal to human organ or tissue transplant.

H. Nutritional Support (Requires HNE's Prior Approval): **You Pay… $0**

HNE covers specific nutritional support as described below.

WHAT IS COVERED:

HNE covers the following when Medically Necessary and ordered by an In-Plan Doctor:

- Nutritional support, including enteral tube feedings, when the Member has a permanent impairment involving the gastrointestinal tract that prevents adequate oral nutritional intake.
- Parenteral nutrition and total parenteral nutrition.
- Special medical foods that are taken orally and prescribed for:
  - Phenylketonuria (PKU).
  - Tyrosinemia.
  - Homocystinuria.
  - Maple syrup urine disease.
  - Propionic acidemia.
  - Methylmalonic acidemia in a Dependent child.
  - Protection of an unborn fetus of a pregnant Member with PKU.
- Non-prescription enteral formulas for home use that are Medically Necessary for the treatment of malabsorption caused by:
  - Crohn's disease.
  - Ulcerative colitis.
  - Gastroesophageal reflux.
  - Gastrointestinal motility.
  - Chronic intestinal pseudo-obstruction.
  - Allergic enteropathy, including allergic colitis.
  - Low protein food products for inherited disease of amino acids and organic acids. *Coverage for low protein food products will not exceed $2,500 per Member per Calendar Year.*

WHAT IS NOT COVERED:

Dietary supplements, specialized infant formulas (such as Nutramigen, Elecare, and Neocate), vitamins and/or minerals taken orally to replace intolerable foods, supplement a deficient diet, or provide alternative nutrition for conditions such as hypoglycemia, allergies, obesity, and gastrointestinal disorders. These products are not covered even if they are required to maintain weight or strength.

I. Cardiac Rehabilitation: **You Pay… $10 per visit**

HNE covers the multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease. HNE covers such care when received in a hospital or from another In-Plan Provider, and when the care meets standards issued by the Commissioner of Public Health. Such standards will include, for example, outpatient treatment, if the treatment is started within 26 weeks after the diagnosis of the disease.

J. Nurse Anesthetists and Nurse Practitioners: **You Pay… $10 per visit**

HNE covers services provided by a certified registered nurse anesthetist or nurse practitioner that participates with the Plan, if the following conditions are met:

1. The service rendered is within the scope of the certified registered nurse anesthetist's license or the nurse practitioner's authorization to practice by the Board of Registration in Nursing; and
2. HNE covers the identical services when rendered by other licensed providers of health care.

K. Scalp Hair Prostheses (Wigs): **You Pay… All costs over $350**

HNE covers scalp hair prostheses (wigs) worn for hair loss due to the treatment of any form of cancer or leukemia. HNE will reimburse the Member up to $350 toward the cost of the wig. This benefit is limited to $350 per Calendar Year. You must send your request for reimbursement to the HNE Member Services Department. The request must include proof of payment and a written statement from your physician that the wig is Medically Necessary.

L. Coronary Artery Disease/Change of Heart* Program*: **You Pay…10% of cost of program**

Coverage for this program will be provided to Members with documented coronary artery disease, diabetes or high cholesterol to help participants reduce disease risk factors through lifestyle changes. *The program must be authorized by your PCP.*

M. Hearing Aids: **You Pay…See below**

HNE will provide coverage for hearing aids at 100% for the first $500 and 80% coverage for the next $1,500 per person every two Calendar Years.

N. Nutritional Counseling: **You Pay…$10 per visit**

HNE covers up to a maximum of four outpatient visits per Calendar Year for nutritional counseling.

O. Hormone Replacement Therapy (HRT): You Pay…*applicable* prescription drug Copayment

HNE covers hormone replacement therapy service for peri- and postmenopausal women.

P. Cancer Clinical Trials:

HNE covers patient care items and services provided in a cancer clinical trial, as long as:

- The trial meets the definition of a "qualified clinical trial" as contained in Massachusetts General Laws Chapter 176G, section 4P.
- The service or item:
  - is consistent with the usual and customary standard of care;
  - is consistent with the study protocol for the clinical trial; and
  - would be covered if the Member did not participate in the clinical trial.

WHAT IS NOT COVERED:

- An investigational drug or device paid for by the manufacturer, distributor or provider of the drug or device.
- Non-health care services that a Member may be required to receive as a result of being enrolled in the clinical trial.
- Costs associated with managing the research associated with the clinical trial.
- Costs that would not be covered for non-investigational treatments.
- Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the clinical trial.
- The costs of services which are inconsistent with widely accepted and established national or regional standards of care.
- The costs of services which are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements, and other services which are typically covered but which are being provided at a greater frequency, intensity or duration.
- Services or costs that HNE does not cover.

Q. Special Programs and Discounts:

By joining HNE, you may have access to special programs and discounts, such as discounts on health education classes, acupuncture, and massage therapy. Please contact HNE for the most current listing of all of HNE's special programs and discounts, as these programs and discounts may change from time to time.

SECTION 4 – EXCLUSIONS AND LIMITATIONS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- Some services are not covered.
- Some services that are covered have specific limitations.

HNE excludes all services, supplies, and other items of care not specifically included in this Member Handbook. Coverage is subject to the terms and conditions of this Member Handbook. For example, services must be Medically Necessary. HNE does not limit or exclude coverage for pre-existing conditions. **Please also see the descriptions of individual benefits for services that are limited or partly excluded.**

HNE excludes the following services and supplies:

1. Acne-related services, such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or other procedures to plane the skin. (Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.)
2. Acupuncture.
3. ALCAT test for food sensitivity.
4. All medical, hospital, or other health care services or supplies provided by an Out-of-Plan Provider, unless approved by an In-Plan Doctor *and* HNE in accordance with HNE policies and rules. HNE *will* cover services or supplies rendered by Out-of-Plan Providers in cases of an Emergency Medical Condition. See "Emergency Care" in Section 2.
5. Alternative medicine.
6. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training and/or educational therapy for learning disabilities, or other educational services such as educational testing.
7. Any services that are the legal liability of Workers' Compensation Insurance or other third party insurer.
8. Any services provided by the Veterans Administration for service-connected disabilities to which Members are legally entitled and for which facilities are reasonably available.
9. Arch supports, foot orthotic devices, and corrective shoes except as required by law.
10. Care or treatments provided by family members.
11. Chiropractic care.
12. Contact lenses are covered only for: cataract after extraction; keratoconus; aphakia; or following a cornea transplant, for up to one year, if Medically Necessary. A lens applied as a bandage lens following an eye injury or to treat a diseased cornea is covered.
13. Continuous Glucose Monitoring Systems
14. Cosmetic or beautifying surgeries, procedures, drugs, services, or appliances. See page 41

15. Dermatoscopy for detection of melanoma.
16. Diagnostic tests analyzed in functional medicine laboratories such as Genova Diagnostics.
17. Dietary supplements.
18. Educational service or testing, except services covered under the benefit for early intervention services described in Section 3 – Covered Benefits.
19. Elective treatment or surgery not required by your medical condition, according to the judgment of the Plan.
20. Experimental implants are not covered. Non-experimental implants are covered only when Medically Necessary due to a functional defect of a bodily organ and when the implant will serve to restore full normal function. (Note: This refers to implants. Coverage and exclusions for transplants are described in Section 3.)
21. Extracorporeal Shock Wave Therapy (ESWT) for Chronic Plantar Fasciitis.
22. Eyeglasses.
23. Fees to a donor or program for donation of sperm/egg(s).
24. Gender reassignment operations and treatments.
25. Holistic treatments.
26. INJEX™/ROJEX™ needle-free system.
27. Items not listed or listed as "not covered" on the DME and medical and surgical supplies list.
28. Laser treatment for psoriasis.
29. Laser vision correction surgery.
30. Medical care that HNE's Medical Director determines is experimental, investigational, or not generally accepted in the medical community. Experimental means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are considered to be unsafe, experimental, or investigational. This is determined by, among other sources, formal or informal studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies, experts in the field, and any other association or federal program or agency that has the authority to approve medical testing or treatment.
31. Medical expenses incurred in any government hospital or facility or for services of a government doctor or other government health professional.
32. Neurobiofeedback.
33. Nutritional supplements except as described under "Nutritional Support" in Section 3 of this Agreement.
34. Orthoptics.
35. Provider charges for shipping or copying medical records or for failing to keep an appointment.
36. Reduction mammoplasty for male gynecomastia.
37. Routine foot care, which includes but is not limited to:
    - Cutting or removal of corns and calluses, plantar keratosis
    - Trimming, cutting and clipping of nails

- Treatment of weak, strained, flat, unstable or unbalanced feet
- Other hygienic and preventive maintenance care considered self-care (i.e. cleaning and soaking the feet, and the use of skin creams to maintain skin tone)
- Any service performed in the absence of localized illness, injury or symptoms involving the foot.

HNE covers routine foot care if you are a diabetic.

38. Sclerotherapy, joint and ligamentous injections (Prolotherapy) for non-symptomatic varicose veins.
39. Services and treatment not in keeping with national standards of practice, as determined by the Plan's Medical Director or his/her designees, including but not limited to: nutritional based therapies, non-abstinence based substance abuse care, crystal healing therapy, rolfing, regressive therapy, EST, and herbal therapy.
40. Services authorized to be provided under MGL Chapter 71B in Massachusetts (referred to as "Chapter 766") or Section 10-76A-d of the General Statutes in Connecticut. These services include, for example:
    - Adaptive physical education.
    - Physical and occupational therapy.
    - Psychological counseling.
    - Speech and language therapy.
    - Transportation.

    Members who believe that their child may be handicapped (physical disability, mental retardation, learning problem, or behavioral problem) should seek a Chapter 766 or a Section 10-76A-d evaluation. Members must make appropriate and reasonable efforts to obtain benefits available under state law.
41. Services or supplies, other than those referred to in item 42 below, which are paid for, or with respect to which benefits are actually provided, under any law of a government (national or otherwise) except where such payments are made or such benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents.
42. Services or supplies which are furnished or paid for, or with respect to which payments are actually provided, under any law of a government (national or otherwise) by reason of the past or present service of any person in the armed forces of a government.
43. Services received after the date that coverage ends.
44. Services rendered outside the HNE Service Area, when the Member could have foreseen the need for such services before leaving the Service Area. This exclusion will apply unless HNE has approved such services in advance.
45. Special duty or private duty nursing and attendant services.
46. Specialty clothing appropriate to specific medical conditions.
47. Sperm or egg banking not connected with approved Infertility treatment for an active cycle.
48. Tinnitus masker.

49. Travel, transportation and lodging expenses for a Member and/or a Member's family as a course of treatment or to receive consultation or treatment.
50. Treatment by telephone.
51. Vocational rehab, including job retraining, or vocational and driving evaluations focused on job adaptability, or therapy to restore function for a specific occupation.
52. Weight control programs.

COSMETIC SERVICES

HNE does not cover cosmetic services, follow up treatment for cosmetic services, or treatment for complications resulting from cosmetic procedures. The primary purpose of cosmetic or beautifying surgeries, procedures, drugs, services, or appliances is to improve, alter or enhance appearance or self image. They are not necessary to maintain or restore an essential bodily function, or they are performed for psychological or emotional reasons.

Below are some examples of procedures that are considered cosmetic in nature and are not covered:

- Botox injections for cosmetic purposes
- Breast implants
- Chemical exfoliation for acne
- Chemical Peel
- Chin implant (Not covered except for correction of deformities that are secondary to disease, injury or congenital defect.)
- Collagen implant (e.g. Zyderm)
- Correction of diastsis recti abdominis
- Dermabrasion for removal of acne scars
- Earlobe repair to close a stretched or torn ear pierce hole
- Electrolysis for hirsutism
- Excision of excessive skin on thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad or other areas
- Excision or repair of keloid
- Grafts, fat
- Otoplasty
- Reduction of labia minora
- Removal of spider angiomata
- Rhytidectomy
- Salabrasion
- Scar revision
- Suction assisted lipectomy

This list is not exhaustive, and any procedure considered cosmetic in nature will be excluded.

SECTION 5 – CLAIMS AND UTILIZATION MANAGEMENT PROCEDURES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- Some procedures require HNE's Prior Approval. Procedures requiring Prior Approval are listed in this section.
- HNE also performs retrospective and concurrent reviews as part of its Utilization Management program.

UTILIZATION MANAGEMENT PROGRAM

The purpose of HNE's Utilization Management program is to review certain claims to determine if they are Covered Services and if they are Medically Necessary and appropriate. There may be times when a service is not approved. When this occurs, coverage for the services may be denied. A utilization management denial may be made only on the basis of whether it is Medically Necessary or appropriate or if it is not a Covered Service under the Plan. HNE knows that there is a risk of under-utilization of necessary health care services. It therefore states that:

- HNE's utilization management programs have been designed to ensure that medical decision-making is based on the appropriateness of care and services and the existence of coverage.
- HNE encourages all clinicians and administrative staff who are involved in utilization management review to work collaboratively to help Members obtain access to appropriate health care resources.
- HNE does not provide compensation or other financial incentive or reward to its In-Plan Providers or staff who conduct utilization management review that is based on the quantity or type of denial decisions rendered.

PROCEDURES THAT REQUIRE HNE'S PRIOR APPROVAL

In order to obtain coverage for certain services and procedures, your Primary Care Physician or treating In-Plan Provider is required to get HNE's Prior Approval. Your Primary Care Physician or treating In-Plan Provider must get HNE's Prior Approval if you plan to have any of the following services or procedures:

- Abdominal panniculectomy
- All elective obstetrical admissions
- Blepharoplasty
- Botox injections for all indications (HNE's Pharmacy Benefit Manager reviews Prior Approval requests for these services)
- Certain durable medical equipment (see page 31 for specific items)
- Chair van services and non-emergency transportation by ambulance
- Cochlear implants
- Computerized Tomography (CT) scans
- Diabetic teaching

- Female reduction mammoplasty
- High frequency chest wall compression devices
- Hospice services
- Hospital and anesthesia services for dental procedures required by Members with a serious medical condition
- Human Organ transplants
- Infertility treatment (Prior Approval is required for Assisted Reproductive Technologies [ARTs] such as IVF, GIFT, ZIFT, ICSI, donor egg, FET services and related ART medications. Prior Approval is not required for evaluation, artificial insemination/Intra-Uterine Insemination (AI/IUI) services)
- Injectable Drugs. The below injectable drugs also require Prior Approval. They are part of your medical benefit and not part of your prescription drug benefit. Prior Approval for these drugs is done by HNE's Pharmacy Benefit Manager:
    - Amevive®
    - Botox
    - Growth Hormone
    - Remicade®
    - Xolair®
- Intravenous Immunoglobulin (IVIg) therapy
- Laser-assisted uvulopalatoplasty or uvulopalatopharyngoplasty (corrective surgery of the palate, uvula, or related structures)
- Magnetic Resonance Angiogram (MRA)
- Magnetic Resonance Imaging (MRI)
- Mandibular advancement device for treatment of obstructive sleep apnea
- Neuropsychological testing. (For Prior Approval, call HNE's Behavioral Health Triage Unit at 800-842-4464 ext. 5028)
- Nutritional Support
- Oral surgery for treatment of non-dental conditions
- Outpatient hyperbaric oxygen therapy
- Outpatient mental health and substance abuse services
- Positron Emission Tomography (PET) scans
- Prosoba column
- Pulmonary rehabilitation
- Rhinoplasty
- Self-monitoring of anti-coagulant therapy
- Services from Out-of-Plan Providers
- Skilled home care services, including home infusion; perinatal monitoring; skilled nursing care; and home physical, occupational, and speech therapy
- Sperm storage
- Surgical management of morbid obesity
- Any other services listed in this Member Handbook that indicate that Prior Approval is necessary

HNE will notify you of any changes to this list through our Member newsletter or through a direct mailing.

Prior Approval Process

To get HNE's Prior Approval, have your treating In-Plan Provider send a Prior Approval Request Form or, for Infertility treatment, an Infertility Prior Approval Request Form, to HNE's Health Services Department. In reviewing these requests, HNE may consider whether the service:

- Is a Covered Service
- Is Medically Necessary
- Is being provided in the appropriate setting
- Follows generally accepted medical practice
- Is available within the HNE network
- Meets HNE's clinical criteria for coverage

Your treating In-Plan Provider may also contact HNE by phone. This should be done at least seven days before the date of your procedure. HNE will make a decision on your request within two working days of receiving all necessary information. If HNE approves coverage for your service or procedure, we will inform the provider rendering the service by phone within 24 hours and in writing to you and that provider within two working days thereafter.

If HNE denies coverage, we will inform the provider who is rendering the service by phone within 24 hours that our criteria have not been met. You and your provider will be informed in writing within one working day thereafter.

If your request is urgent, HNE will make a decision and notify you and your provider in writing within 2 business days of receiving all information, or within 72 hours of receipt of your request, whichever is earlier.

If you have requested a service that requires HNE's Prior Approval and would like to know the status or outcome of the review, you may call 800-310-2835. You may also call HNE's Health Services Department if you would like a copy of the clinical criteria HNE uses to make its determinations.

To find out if a particular durable medical equipment item requires Prior Approval, please refer to page 31 or call Member Services at the number at the bottom of this page.

If HNE reviews a procedure or hospital admission, it does not mean that the Plan will cover all charges. Benefit determinations will be made by HNE according to all the terms of this Member Handbook. Benefits for treatment, services, or supplies that are not covered under this Member Handbook may be denied.

CONCURRENT REVIEW PROCEDURES

For certain procedures and services, such as inpatient hospital stays and ongoing courses of treatment, HNE may pre-approve the service or procedure. However, HNE will then review the Medical Necessity and appropriateness of the procedure during your stay or during the course of your treatment. This is called "concurrent review." If, based on this concurrent review, HNE decides to terminate or reduce your coverage, we will notify you in writing prior to the reduction or termination of the service.

In the case of a decision to approve an extended stay or additional services, we will notify your provider by telephone within one working day, and send written or electronic confirmation to you and your provider within one working day thereafter. A written or electronic notification will include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services. In the case of an Adverse Determination, we will notify your provider by telephone within 24 hours, and send written or electronic notification to you and your provider within one working day thereafter. The service shall be continued without liability to you until you have been notified of the determination.

If you decide to appeal our decision, HNE will continue to cover the services until your appeal is completed. Any request to extend the course of treatment involving urgent care will be decided and communicated within 24 hours after receipt (provided that the request is made at least 24 hours prior to the expiration of the course of treatment).

RETROSPECTIVE REVIEW PROCEDURES

Retrospective review is an initial review of any service that was already received by a Member. If HNE determines that the service was not Medically Necessary or appropriate, HNE may deny the claim for benefits. HNE will notify you of any claims denied on this basis within thirty (30) days of HNE's receipt of the claim.

WRITTEN NOTIFICATION OF AN ADVERSE DETERMINATION

If we decide not to approve coverage based upon medical necessity and appropriateness, we will send you and your provider a written notification of the Adverse Determination. The written notice will include a substantive clinical reason that is consistent with generally accepted principles of professional medical practice.

We will:

- Identify the specific information on which the Adverse Determination was based;
- Discuss your presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
- Specify alternative treatment options covered by HNE, if any;
- Reference and include applicable clinical practice guidelines and review criteria;
- Offer your doctor or treating practitioner the opportunity for a case discussion or reconsideration (see below); and
- Provide you with a clear, concise and complete description of HNE's grievance process and the procedures for obtaining external review pursuant to 105 CMR 128.400.

CASE DISCUSSION AND RECONSIDERATION PROCESSES

If your doctor or treating practitioner disagrees with an Adverse Determination, he or she may request a case discussion with an HNE physician reviewer. This discussion may result in the reversal of HNE's decision. Your doctor or treating practitioner may also request a reconsideration of our decision from a

clinical peer reviewer. This will be conducted between your doctor or treating practitioner and the clinical peer reviewer within one working day of the request. If you are still dissatisfied, you may request a clinical appeal or an expedited appeal. Your doctor or treating practitioner may also request a clinical appeal or an expedited appeal on your behalf. The case discussion and reconsideration processes are not prerequisites to the HNE grievance process or an expedited appeal. For more information, see Section 6.

SECTION 6 – INQUIRIES AND GRIEVANCES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- If you have a complaint about the care you have received or about HNE's service, we want to know.
- If you are not satisfied with any aspect or action of HNE, you may have the right to appeal.

INQUIRY PROCESS

An "inquiry" is any communication that requests redress of an HNE action, omission, or policy. If you have an inquiry:

- Please call us. We will review your inquiry and respond by phone or letter within three business days.
- We will then ask you if you are satisfied with our response. If you tell us that you are not satisfied, we will offer to start a review of your complaint through the internal grievance process.
- We can start this review process over the telephone. If you choose not to start a grievance during our call, we will send you a letter to explain your right to have your inquiry processed as an internal grievance. If your concern is about a provider or provider office, HNE may share the details of your concern with that provider or office.
- The inquiry process is not used to review Adverse Determinations. Adverse Determinations must be reviewed through the internal grievance process, which is described below.

INTERNAL GRIEVANCE PROCESS

This section describes key terms, how to submit a grievance, and what to expect from HNE. A "grievance" is any oral or written complaint about any aspect or action of HNE relative to the Member or about quality of care or Plan administration. Grievances also include benefit appeals and appeals of Adverse Determinations or clinical appeals. The following chart describes the different types of grievances and the time frames within which HNE must respond to your grievance. Please note that the time limits in this section may be waived or extended if both HNE and the Member agree. All time frames begin on the date that HNE receives your grievance, on the date you notify HNE that you are not satisfied with the response to an inquiry, or on the day immediately following the three-business day period for processing inquiries, if HNE was unable to address your inquiry within that time. Any grievance not properly acted on by HNE within the specified time limits (which include any agreed-upon extensions) will be resolved in favor of the Member. Any agreement to waive or extend time limits shall state the new time limits that apply and will not be longer than 30 business days from the date of the signed agreement.

Overview: Grievances and Decision Time Frames Please note that this chart is for quick reference only. Refer to the explanations in this section for further detail.		
Type of Grievance	**Example**	**HNE will respond within:**
Complaint	An inquiry that is not resolved to a Member's satisfaction, or a complaint about a provider or a plan policy or procedure that causes concern to a Member.	30 business days
Benefit Appeal	Appeal of a service or request that is denied as "not a covered benefit" because it is excluded from coverage by your plan.	
Pre-Service	Appeal of a benefit denial for a service you have not received yet.	30 calendar days
Post-Service	Appeal of a benefit denial for a service you have already received.	30 business days
Clinical Appeal	Appeal of a decision that was based upon a review of information provided, to deny, reduce, change or end coverage of a health service for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.	
Pre-Service	Appeal of a clinical denial for a service you have not received yet.	30 calendar days
Post-Service	Appeal of a clinical denial for a service you have already received.	30 business days
Expedited Appeal	Appeal of a clinical denial for a service that your doctor feels is urgent, or for continued coverage while you are still in a hospital stay.	
Urgent Care	Any request for medical care or treatment that requires an expedited review because delaying care in order to follow the timeframe for non-urgent care: • Could seriously jeopardize your life or health or ability to regain maximum function, based on a prudent layperson's judgment or • In the opinion of your provider, would subject you to severe pain that cannot be adequately managed without the requested care.	72 hours
Inpatient	Appeal of a clinical denial for continued coverage of a hospital stay while you are still in the hospital.	Before you are discharged

Overview: Grievances and Decision Time Frames Please note that this chart is for quick reference only. Refer to the explanations in this section for further detail.		
Type of Grievance	**Example**	**HNE will respond within:**
Immediate (requires certification)	Services or durable medical equipment that your doctor certifies is Medically Necessary and, if not immediately provided, could result in serious harm to you.	Upon certification, reversal within 48 hours (or sooner)
Expedited Appeal for a terminally ill Member	Complaints, Benefit Appeals and Clinical Appeals are decided according to this time frame for a terminally ill Member unless the request for review qualifies as an Expedited Appeal as listed above.	5 business days

SUBMITTING YOUR GRIEVANCE

You must submit your grievance within 180 calendar days after you receive notice that HNE has denied your claim for services. You may submit your grievance by telephone, in person, by mail, or by electronic means. Please include the following information:

- ✓ Member ID number.
- ✓ Daytime telephone number.
- ✓ Detailed explanations of your grievance and any applicable documents related to your grievance, such as copies of medical records or billing statements.
- ✓ Specific resolution you are requesting.
- ✓ Any other documents that you feel are relevant to the review.

You may contact us by:

Mail: Health New England
Complaint and Appeals Department
One Monarch Place
Springfield, MA 01144-1500

Fax: 413-233-2685
(For complaints and appeals only, if you are faxing information on a billing issue, please fax to Member Services at 413-233-2655.)

Telephone: 800-310-2835 or 413-787-4004

Electronically: To find out how, please call HNE Member Services at the number at the bottom of this page.

Your authorized representative may also submit the grievance on your behalf. If you submit a grievance by mail, HNE will send a written acknowledgement of receipt of your grievance within five business days. If you submit your grievance orally, HNE will put your grievance in writing and send a copy to you within 48 hours. If your grievance is about a clinical denial, we may ask you to sign a form releasing your medical or treatment information to HNE.

REVIEW PROCESS

HNE will fully investigate the substance of all complaints and appeals. All appeals will be reviewed by a person or persons who were not involved in the initial decision nor subordinates of anyone involved in the initial decision.

Requests for Medical Records

In most cases, HNE either already has the medical records relevant to your grievance or HNE can obtain the records without obtaining a signed medical record release from you. In some cases, however, such as when we need records from out-of-plan providers, HNE may need to ask you to submit a medical record release in order to obtain the records.

If HNE has asked you to agree in writing to the release of your medical records, we will also ask you to agree, in writing, to an extension of up to 30 business days after you return the release to issue a decision. If you choose not to sign the release, or if HNE does not receive a signed release within the required time limit (refer to the Overview chart above), we may, at our discretion, issue a decision without review of some or all of your medical records.

If HNE does issue a decision without review of all your medical records, HNE may offer you a reconsideration. HNE will only offer this if, through no fault of your own, relevant medical information was received too late to review within the required time limit (refer to the Overview chart above) or was not received but is expected to become available within a reasonable time period following the written resolution. If HNE offers you a reconsideration based on these facts, HNE will agree in writing on a new time period for review, but in no event greater than 30 business days from the agreement to reconsider. The time period for requesting external review will begin to run on the date of the resolution of the reconsidered grievance.

Complaints and Benefit Appeals

A person knowledgeable about the subject matter of your complaint or benefit appeal will review it and issue a decision based on all available information.

Appeals of Clinical Denials

A practitioner who is actively practicing and who was not involved in the initial decision will review your appeal. This practitioner will have clinical expertise in those medical issues that are the subject of the appeal.

If you do not agree with HNE's decision, in many cases, you have a right to an external review. See "External Appeals Process" later in this section.

If a grievance is filed concerning the termination of ongoing coverage or treatment that HNE previously approved, HNE will continue to cover the disputed service or treatment through the completion of the internal grievance process regardless of the final decision. HNE will not continue to cover medical care that was terminated pursuant to a specific time or episode-related exclusion.

Expedited Review Process: For Urgent, Inpatient, or Immediately Needed Services
HNE will "expedite" the review of an appeal for coverage of services that are immediate or urgently needed. A practitioner who is actively practicing and who was not involved in the initial decision will review your appeal. This practitioner will have clinical expertise in those medical issues that are the subject of the appeal.

If you are an inpatient in a hospital, HNE will make a decision on your grievance before you are discharged from the hospital. In all other cases, HNE will make a decision on your grievance and notify you and your provider within 72 hours of receipt of your request.

For services or durable medical equipment that, if not immediately provided, could result in serious harm to you, HNE will reverse its decision to deny coverage within 48 hours (or sooner in some cases) pending the outcome of the grievance process. For a reversal to occur within 48 hours, your doctor must certify that:

1. The service or durable medical equipment at issue in your appeal is Medically Necessary.
2. The denial of coverage would create a substantial risk of harm to you.
3. Such risk of serious harm is so immediate that the provision of such services or DME should not await the outcome of the normal grievance process.
4. The reversal will last until the appeal is decided.

If the physician requests automatic reversal earlier than 48 hours for DME, the physician must further certify as to the specific, immediate and severe harm that will result to the patient absent action within the 48 hour time period.

Expedited Review Process: For Members with a Terminal Illness
A person knowledgeable about the subject matter will review a complaint or benefit appeal. A practitioner who is actively practicing and who was not involved in the initial decision will review clinical appeals. This practitioner will have clinical expertise in those medical issues that are the subject of the appeal. HNE will make a decision on your grievance within five business days of receipt. If a Member with a terminal illness appeals a decision of an immediate or urgently needed service, HNE will make a decision on your grievance and notify you and your provider within the timeframes listed above for expedited appeals.

If HNE continues to deny coverage or treatment, you have the right to request a conference. HNE will schedule a conference within 10 days of receipt of your request. If your doctor, after consulting with HNE's Medical Director, decides that the effectiveness of the proposed service or treatment would be materially reduced if it is not provided at the earliest possible date, HNE will schedule the hearing

within five business days. You and/or your authorized representative may attend the conference. HNE will authorize its representative at the conference to decide your grievance.

OUR WRITTEN RESPONSE

HNE's written response to your grievance will:

- Include the specific reason for the decision.
- Identify the specific information on which the decision was based.
- Reference and include the specific plan provisions on which the decision was based.
- Specify alternative treatment options covered by HNE, if any.
- Notify you of the process for requesting an external review or, where applicable, an expedited external review.

In addition, for clinical appeals, the written response will also:

- Include a substantive clinical reason that is consistent with generally accepted principles of professional medical practice.
- Discuss your presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet HNE's medical review criteria.
- Reference and include applicable clinical practice guidelines and review criteria.

You also have the right to request copies, free of charge, of all documents, records or other information relevant to your appeal.

EXTERNAL APPEAL PROCESS

If HNE has denied your clinical appeal and you do not agree with HNE's decision, you can ask for an external appeal. To do so, you need to file a written request with the Department of Public Health, Office of Patient Protection. HNE will provide you with the necessary filing forms when it notifies you of its final decision. You can also obtain the necessary forms by calling OPP or accessing its web site. The fee for filing an appeal is $25. This fee may be waived by OPP if it determines that the payment of the fee would result in an extreme financial hardship to the Member. Information on contacting OPP is at the end of this section. You must submit the request within 45 days after you receive HNE's final decision on your appeal. A request for external review can be submitted by you or your authorized representative, and the request must include:

1. The signature of you or your authorized representative consenting to the release of medical information, and
2. A copy of the written final Adverse Determination from HNE.

The OPP will screen appeal requests. The OPP screening determines whether the request:

- Complies with OPP's requirements for external review requests (such as the $25 filing fee).
- Involves a service or benefit that has been explicitly excluded from coverage.
- Is the result of a final Adverse Determination.

Requests that pass the screening are sent to an independent review panel chosen by OPP. If the service or treatment you are requesting is a Covered Benefit, the appeal panel will decide if it is Medically Necessary. The panel will notify you and HNE of its decision within 60 business days of receipt of the request for review, unless it determines that it needs additional time. The panel may extend the time by an additional 15 days. Your doctor can ask the panel to decide more quickly (an expedited review). If the panel agrees, it will decide within five business days. The decision of the review panel is final and binding.

Expedited External Review Process

You, or your authorized representative, can ask the panel to decide more quickly by requesting an expedited review. The request for an expedited external review must contain a certification, in writing, from your physician, that a delay in providing the health care services would pose a serious and immediate threat to your health. The OPP will screen the request within 48 hours of receipt. The OPP screening determines whether the request complies with the OPP's requirements for expedited external review requests. If the panel agrees to handle the requested as an expedited external review, it will decide the request within five business days. The decision of the review panel is final and binding.

If the subject of the external review involves the termination of ongoing services, you may ask the external review panel to continue coverage for the terminated service while the review is pending. Any such request must be made before the end of the second business day following receipt of the final Adverse Determination. The review panel may allow your request if it determines that substantial harm to your health may result without such continuation or for such other good cause as the review panel shall determine. Any such continuation of coverage will be at HNE's expense regardless of the final external review decision.

MASSACHUSETTS OFFICE OF PATIENT PROTECTION

Massachusetts has set up an Office of Patient Protection within the Department of Public Health. This office will accept consumer complaints and manage the external review process described above. The following information is also available from the Office of Patient Protection:

- A list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of health care services offered by HNE.
- The percentage of doctors who voluntarily and involuntarily ended their participation with HNE during the previous Calendar Year for which such data has been compiled and the three most common reasons for voluntary and involuntary disenrollment.
- The percentage of premium revenue HNE spends for health care services for the most recent year for which data is available.
- A report detailing, for the previous Calendar Year, the total number of filed grievances, grievances that were approved internally, grievances that were denied internally, grievances that were withdrawn before resolution, and external appeals pursued after exhausting the internal grievance process and the resolution of all such appeals.

How to contact the Office of Patient Protection:

Toll-free telephone:	800-436-7757
Fax:	617-624-5046
Web site:	www.mass.gov/dph/opp/

SECTION 7 – ELIGIBILITY

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- To be eligible as a Member you normally must live in the HNE Service Area.
- Eligibility depends on the terms of the Group Insurance Commission contract.
- Dependent coverage normally ends at age 19.
- HNE may require reasonable evidence of eligibility from time to time.

The Group Insurance Commission determines the eligibility of any person, whether it be an employee, retired employee, dependent of an employee, dependent of a retired employee, surviving spouse of a deceased employee or retiree or surviving dependent of a deceased employee, retiree or surviving spouse. Health New England offers this health plan for Medicare enrolled retirees in addition to its regular plan for non-retirees. If you are an eligible retired employee of the Commonwealth, you may join this plan. To enroll you must have Medicare hospital (Part A) and medical (Part B) insurance coverage. If you have a spouse or eligible dependent who is not covered by Medicare, they may enroll in Health New England's non-Medicare coverage, to the extent described in this Member Handbook (*see also* Section 10, Continuation of Coverage Options).

An individual membership covers the retired employee only. The retiree's spouse may also be covered under this plan if he or she has Medicare hospital and medical insurance coverage. A spouse or dependent not eligible for Medicare may be covered under Health New England's non-Medicare coverage plan. HNE may require proof of eligibility from time to time.

RESIDENCY REQUIREMENT

To be eligible for coverage under the Plan, you must live, and maintain a permanent residence, within the HNE Service Area for at least nine months per year. This requirement does not apply to a Dependent child who is enrolled as a full-time student.

SUBSCRIBERS

To be eligible as a Subscriber in this Plan, you must be:

- A retired state employee, Retired Municipal Teacher or Elderly Government Retiree who is eligible for, and enrolled in, Medicare Part A & Part B. HNE will coordinate benefits according to Medicare's determination of which coverage is primary. However, HNE will not cover services, except those for emergencies, unless you use In-Plan Providers and follow the rules in this handbook. If you do use In-Plan Providers for Covered Services, you will not have to pay any Medicare deductibles or coinsurance. If you do not use In-Plan Providers, you may be entitled to Medicare coverage, but not to any HNE coverage. You must also tell HNE if you or a family member is eligible for Medicare.

DEPENDENTS

To enroll as a Dependent, you must meet the GIC's eligibility rules and be either:

- The legal (married) spouse of the Subscriber.
- In some cases, the divorced spouse of the Subscriber, as described in the "Divorced Spouses" section below.
- A child of the Subscriber or the Subscriber's spouse who meets *all* of the following criteria:
  - is unmarried,
  - lives with the Subscriber or the Subscriber's spouse, and
  - is less than 19 years of age.
- An adopted child of the Subscriber or the Subscriber's spouse who meets *all* of the requirements in the third bullet, and as described in the "Adopted Dependents" section below.
- A child for whom the Subscriber has been named legal guardian and who meets *all* of the requirements in the third bullet. The Subscriber must enroll the child as a Dependent within 31 days after being named legal guardian by the court. Children under legal guardianship will normally be covered from the date the Subscriber was named legal guardian by the court.
- A child of an eligible Dependent who meets *all* of the criteria listed in the third bullet, until the parent is no longer a Dependent.
- An unmarried child of the Subscriber who is under 19 years old and for whom the Subscriber is required by a Qualified Medical Child Support Order to provide health coverage.
- A student Dependent, as described in the "Student Dependents" section below.
- A disabled Dependent, as described in the "Disabled Child Dependents" section below.

ADOPTED DEPENDENTS

When can I enroll a child whom I have adopted or am trying to adopt?

The Subscriber may enroll a child that he/she has adopted within 31 days of the date of filing the adoption petition. In all other cases, HNE covers the child from the date that the child has been placed for adoption in the Subscriber's home by a licensed placement agency. The Subscriber must enroll the child as a Dependent within 31 days of the date of placement.

STUDENT DEPENDENTS

What happens when my child turns 19?

When a Dependent child turns 19 years old, coverage ends at the end of the Dependent child's birthday month. Prior to a Dependent child reaching age 19, a letter is sent to your home address from Health New England. The letter informs you that your Dependent's coverage will end at age 19. The letter also requests information from you which may allow your Dependent to remain covered under the family contract. If your Dependent son or daughter is enrolled as a full-time student at an accredited school, such as a college, junior college, or trade school, he or she is eligible to continue coverage. *In order to obtain such coverage beyond the age 19 termination date, you must contact the Group Insurance Commission and fill out an application with the Commission*. Thereafter, twice each Calendar Year, during February and September, an affidavit letter will be sent to your home address to verify your Dependent student's status. The affidavit letter must be executed by you and returned to

HNE within the stated time. If an affidavit letter is not returned to HNE within the stated time, HNE will assume that the Dependent is no longer a full-time student and no longer eligible to remain part of a family contract. The student will then lose HNE coverage as of the last day of the month in which the Dependent last attended school or graduated. A letter of termination will be sent to your home address and a copy of the termination letter will be provided to the Group Insurance Commission.

If the student Dependent continues to meet all other Dependent eligibility criteria his or her coverage will be continued until he or she reaches age 24. Full-time students between ages 19 and 24 may be included in family coverage after their application and confirmation of their status by their educational institution is approved by the Group Insurance Commission.

Student coverage ends at the end of the month in which the student ceases to have full-time student status, or marries.

Students age 24 and older must pay for full-cost individual coverage, with no contribution from the Commonwealth of Massachusetts.

What happens if my son or daughter goes to a school out of the HNE Service Area? Will HNE still cover him/her?

If your child goes to school outside the HNE Service Area, HNE covers him or her for care received outside the HNE Service Area only in an Emergency. **He or she must get all follow-up care and routine care from In-Plan Providers in the Service Area.**

What happens if my Dependent child marries?

When your Dependent child marries, family group coverage ends for him or her at the end of the month in which the marriage takes place.

DISABLED CHILD DEPENDENTS

What happens if my child is disabled when he or she turns 19?

Arrangements may be made to continue coverage for physically or mentally handicapped children age 19 and older who are incapable of self-support at age 19. *Application must be made to the Group Insurance Commission to obtain this coverage. Coverage is subject to Group Insurance Commission approval.* Handicapped children receive their own identification numbers but continue to be considered part of the family policy when benefits are determined.

DIVORCED SPOUSES

What happens if I divorce? Is my former spouse still eligible for coverage?

You and your former spouse should contact the Group Insurance Commission within 60 days of the date your divorce becomes final to determine your divorced spouse's rights to continue group coverage.

Under Massachusetts state law, if you are divorced, your former spouse is eligible to continue as a Dependent on your policy, unless your divorce judgment specifically states otherwise or unless he or

she lives outside the HNE Service Area. Your former spouse may continue as a Dependent on your policy until the earlier of either of the following:

- The time specified in your divorce judgment
- Your former spouse remarries

If your former spouse moves out of the HNE Service Area, he or she will no longer be eligible for Health New England coverage.

In addition, Federal law permits continuation of group health care coverage for divorced spouses. See Section 10.

What happens if I remarry? Is my former spouse still eligible for coverage?

If you remarry and your divorce judgment allows the continuance of health care coverage after your remarriage, your former spouse may continue coverage under an individual policy with a separate premium for that policy. Coverage ends if your former spouse remarries. If your former spouse moves out of the HNE Service Area, he or she will no longer be eligible for Health New England coverage.

In addition, Federal law mandates continuation of group health care coverage for divorced spouses. See Section 10.

SECTION 8 – HOW TO ENROLL AND WHEN COVERAGE BEGINS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- You may enroll within thirty-one days of first becoming eligible.
- You may enroll during your Group's annual Open Enrollment Period.
- The Group Insurance Commission sets your Effective Date of coverage.
- HNE will not provide any coverage before the set Effective Date.
- There are special rules for late enrollments.

Who can enroll?

Only eligible retirees with Medicare Part A and Part B and their eligible Dependents, if any, can enroll in the Plan.

When can a Subscriber enroll?

A Subscriber can enroll in the Plan within 31 days of the date you or your Dependent is first eligible for this coverage, or during the Open Enrollment Period.

Are there any times when I can enroll outside the above time period?

Yes. Under the Health Insurance Portability and Accountability Act (HIPAA), if you did not enroll in the Plan when first eligible, you will be allowed to enroll yourself and your eligible Dependents at a later date if any of the below conditions are met:

- You did not enroll in HNE because you, your spouse, or an eligible Dependent had COBRA continuation coverage under another plan when you otherwise became eligible to enroll in HNE, and that coverage has since been "exhausted."
- You did not enroll in HNE because you, your spouse, or an eligible Dependent had other insurance coverage when you otherwise became eligible to enroll in HNE, and you subsequently lost your eligibility for coverage, or employer contributions toward such coverage were terminated, as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment.
- If you marry.
- If you acquire a new Dependent through birth, adoption, or placement for adoption.

If you meet any of the above conditions, you must make a written request for enrollment to the Group Insurance Commission within 31 days of the date of the event that qualifies you for coverage. Your coverage with HNE will be effective as of the date of the Qualifying Event.

What happens if I am already enrolled but then acquire a new Dependent or marry?

If you acquire a new Dependent or marry, you may add your new Dependent to the Plan. You must notify the Group Insurance Commission within 31 days of the following events:

- Marriage.
- Birth.
- Adoption or placement for adoption.
- Legal guardianship.
- The Subscriber becoming legally responsible for the Dependent's health care coverage.

How do I enroll?

To enroll in HNE you must meet the eligibility requirements of Section 7. You must also submit the following directly to the Group Insurance Commission within 31 days of the requested Effective Date of coverage:

- A completed and signed Group Insurance Commission Enrollment/Change Form, and
- Any other forms or information that HNE may request.

What happens if I am pregnant, have a procedure or visit already scheduled, or have a chronic condition?

Please contact our Health Services Department. A nurse clinical liaison will talk with you about the transition of your care. *This is especially important if you are seeing a provider who is not an In-Plan Provider. You should also read the "Continued Treatment (Transitional Care)" provisions in Section 15.*

SECTION 9 – TERMINATION

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- You may end your coverage at any time.
- HNE may end your coverage for certain specified reasons.
- Your employer may end your coverage.
- If you lose your coverage, you may have the right to continue coverage under the Federal COBRA law or in HNE's Non-Group plan.

HOW THIS AGREEMENT MAY END

HNE may cancel your coverage or refuse to renew your coverage only in the following circumstances:

1. The Commonwealth's agreement with Health New England ends and is not renewed.
2. You commit an act of physical or verbal abuse that poses a threat to providers, other HNE Members or HNE's employees or agents, that is unrelated to your physical or mental condition. At HNE's option, the effective date of termination may be any day after the date of the abuse.
3. You relocate outside the HNE Service Area.

What rights do I have when HNE ends my coverage?

HNE will provide for continuation of benefits to the full extent required by law. See Section 10, "Continuation of Coverage Options." In addition, HNE will cooperate with the Group to facilitate the availability of continued coverage as required by law.

SECTION 10 – CONTINUATION OF COVERAGE OPTIONS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- If you lose your coverage, you may have the right to continue your coverage.
- If you lose your coverage, you have the right to receive evidence of HNE coverage.

SURVIVORS

In the case of the death of an employee or retiree, the surviving spouse may continue health plan coverage until remarriage. The surviving spouse must apply to the Group Insurance Commission for this service within 60 days of the date of the employee or retiree's death.

In the case of the death of a single or divorced employee or retiree, or the surviving spouse of a deceased employee or retiree, Dependent children may continue coverage through this program until age 19 or until they become eligible for other group health coverage, whichever is earlier. Application for continued coverage must be made within 60 days of the death of the insured parent.

MEDICARE ENROLLED RETIREES

Retired state employees who are eligible for, and enrolled in, Medicare Part A & Part B, may enroll in this plan. Health New England will coordinate benefits according to Medicare's determination of which coverage is primary. However, we will not cover services, except those for emergencies, unless you use In-Plan Providers and follow the rules in this handbook. If you do use In-Plan Providers you will pay no Medicare deductibles or coinsurance for these benefits. If you do not use In-Plan Providers or follow the rules in this handbook, you will be entitled to Medicare coverage, but not to any supplemental Health New England coverage. You must also tell HNE if you or a family member is eligible for Medicare.

CONTINUATION COVERAGE UNDER FEDERAL LAW (COBRA)

Under the federal law called COBRA (which stands for the Consolidated Omnibus Budget Reconciliation Act), if you lose Group health insurance coverage, you may have the right to continue coverage for up to 18 for employees, or 36 months for Dependents, at your own expense. In general, you can continue coverage if you lose coverage for any of these reasons:

- The Subscriber leaves employment (except for gross misconduct), is laid off, or has his or her hours reduced.
- A Spouse gets divorced from the Subscriber.
- A child Dependent reaches age 19 or marries.
- A student Dependent is no longer a full-time student or marries.
- The Subscriber dies.

Federal law determines the amount Members pay for coverage and the length of the continuation coverage. For more detailed information about your rights under COBRA, see Appendix A.

CONTINUATION COVERAGE FOR DIVORCED SPOUSES UNDER STATE LAW

Massachusetts law gives Members the right to continue health coverage if they lose their eligibility for coverage following a Divorce. The divorced spouse can also continue coverage under the COBRA law described in "Continuation Coverage under Federal Law," or he or she can convert to Non-Group coverage.

You must notify the Group Insurance Commission within 60 days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later.

CONVERSION TO GUARANTEED ISSUE NONGROUP COVERAGE

Group Subscribers and Dependents who are no longer eligible for Group coverage may be eligible to continue coverage by enrolling in, and paying for, HNE's Guaranteed Issue Non-Group Plan. Call HNE for more information.

YOUR HIPAA PORTABILITY RIGHTS

If you should terminate your GIC health plan coverage, you may need to provide evidence of your prior coverage in order to enroll in another group plan, to reduce a waiting period in another group health plan, or to get certain types of individual coverage, even if you have health problems. This notice describes certain HIPAA protections available to you under federal law when changing your health insurance coverage. If you have questions about your HIPAA rights, contact the Massachusetts Division of Insurance (617-521-7777) or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272.

Using Certificates of Creditable Coverage to reduce pre-existing condition exclusion waiting periods. Some group health plans restrict coverage of individuals with certain medical conditions before they apply. These restrictions, known as 'pre-existing condition exclusions," apply to conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months before the individual's enrollment date. (An enrollment date is the first day of coverage under the plan, or if there is a waiting period, the first day of a waiting period, usually the first day of work). Under HIPAA, pre-existing condition exclusion periods cannot last longer than 12 months after your enrollment date (18 months if you are a late enrollee). Pre-existing condition exclusion periods cannot apply to pregnancy, or to children who enrolled in health coverage within 30 days after their birth, adoption, or placement for adoption.

If your new plan imposes a pre-existing condition exclusion period, the waiting time before coverage begins must be reduced by the length of time during which you had prior 'creditable' coverage. Most health coverage, including that provided by the GIC, Medicaid, Medicare, and individual coverage, is creditable coverage. You may combine any creditable coverage you have, including your GIC coverage shown on this certificate, to reduce the length of a pre-existing condition exclusion period required by a new plan. However, if at any time you had no coverage for 63 or more days, a new plan may not have to count the coverage period you had before the break. (However, if you are on leave

under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without coverage while on FMLA leave do not count towards a 63-day break in coverage).

When you have the right to specially enroll in another plan. If you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. In order to do so, however, you must request enrollment within 30 days of your group coverage termination. Marriage, birth, adoption or placement for adoption can also trigger these special enrollment rights. Therefore, should you have such a life event or your coverage end, you should request special enrollment in another plan as soon as possible if you are eligible for it.

You have the right not to be discriminated against based on health status. A group health plan may not refuse to enroll you or your dependents based on anything related to your health, nor can the plan charge you or your dependents more for coverage, based on health factors, than the amount it charges similarly situated individuals for the coverage.

When you have the right to individual coverage. If you are eligible for individual coverage, you have a right to buy certain individual health policies without being subject to a pre-existing condition exclusion period. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (shown on this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premium;
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.

Therefore, if you are interested in obtaining individual coverage and you meet the criteria to be eligible, you should apply for this coverage as soon as possible to avoid forfeiting your eligibility due to a 63-day break.

SECTION 11 – MEMBERS' RIGHTS AND RESPONSIBILITIES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- As a Member of HNE, you have certain rights and responsibilities.

MEMBERS' RIGHTS

As a Member of HNE, you have the right to:

- Receive information on HNE, its services, In-Plan Providers, policies, procedures, and your rights and responsibilities. HNE will not release information that by law may not be given to Members or any third party. We will not disclose privileged information about In-Plan Providers.
- Be treated with respect and recognition of your dignity and right to privacy.
- Participate with your physician or other health care provider in decisions regarding your health care.
- Expect that your physician or other health care provider will fully and candidly discuss appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage. However, this does not mean that all treatment options are necessarily covered by HNE. If you are unsure about whether a particular treatment is covered, you should contact HNE Member Services.
- Bring grievances and complaints about HNE or care provided by an In-Plan Provider to the attention of HNE, as outlined in our grievance process (see Section 6).
- Refuse treatment, drugs, or other procedures recommended by your physician or other health care provider to the extent permitted by law and to be informed of the potential medical consequences of refusing treatment.
- Select, from HNE's Provider Directory, a Primary Care Physician (PCP) who is accepting new patients.
- Request to change your PCP, as long as the newly chosen PCP has not notified HNE that he or she no longer accepts new patients.
- Have access, during HNE's business hours, to HNE Member Services Representatives who can answer questions and assist in resolving problems.
- Expect that information from your medical records and information about your doctor/patient and hospital/patient relationships will be kept confidential in accordance with state and federal law and as provided by HNE policies and rules.
- Make recommendations regarding HNE's Member rights and responsibilities policies.

MEMBERS' RESPONSIBILITIES

As a Member of HNE, you have the responsibility to:

- Provide, to the extent possible, information to your providers that they need in order to care for you. This includes giving your providers information about your present and past medical conditions, as you understand them, before and during any course of treatment.
- Follow the plans and instructions for care that you have agreed on with your provider.
- Familiarize yourself with your HNE benefits and services by reading materials distributed by HNE and by calling HNE Member Services with any questions.
- Abide by all HNE policies and procedures.
- Treat In-Plan Providers and HNE staff with the same respect and courtesy you expect for yourself.
- Arrive on time for scheduled appointments or give adequate notice if you must cancel or will be late.
- Understand your health problems. If you do not understand your illness or treatment, talk it over with your physician. Understanding your health problems is important to the success of the treatment.
- Participate in decision-making regarding your health care.
- Inform HNE of any other insurance coverage you have so HNE may appropriately administer claims payment and coordinate with other payers.
- Inform HNE of any changes in status that could affect your eligibility for coverage, such as a change of address.
- Assist HNE and In-Plan Providers in obtaining prior medical records when asked to do so. You agree that HNE may obtain and use any of your medical records and other information required to administer the Plan.
- Consider the potential effects if you do not follow your provider's advice. When a service recommended by an In-Plan Doctor is covered, you may choose to decline it for personal reasons. For example, you may prefer to get care from Out-of-Plan Providers rather than In-Plan Providers. In these cases, HNE may not cover substitute or alternate care that you prefer.

SECTION 12 – COORDINATION OF BENEFITS AND SUBROGATION

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- HNE has certain coordination of benefits, reimbursement and "subrogation" rights that are explained in this Section.
- You must cooperate with us and give us the information we need to coordinate benefits or subrogate a claim.

At times, HNE provides coverage for benefits and services under this Member Handbook when it is another plan's duty to pay. If this happens, HNE has the right to recover from a Member's other insurance the value of the services that were provided or arranged by HNE's In-Plan Providers. In addition, whenever payments which should have been made by HNE in accordance with this section have been made by any other plan, HNE will have the right, at its discretion, to pay that plan any amount it determines to be warranted. The amounts paid will be considered benefits paid by HNE. HNE will be fully released from liability under this Member Handbook to the extent of such payments.

For the purposes of this section, HNE may give or obtain any information about a Member that it deems necessary. Any Member claiming benefits under this Member Handbook must provide HNE with the information it needs to carry out this section.

Benefits under this Member Handbook will be coordinated to the extent permitted by law with other plans covering health benefits, including: all health benefit plans, governmental benefits (including Medicare), motor vehicle insurance, medical payment policies, and homeowner insurance.

HNE's rights under this section will remain even after this Member Handbook ends, but only as to services provided while the Member Handbook was in effect.

COORDINATION OF BENEFITS

What happens if I have other group health insurance?

When anyone has coverage with HNE and another Group health plan, it is known as "double coverage." You must tell us if you or a family member has double coverage. You must also send us documents about your other insurance if we ask for them. When you have double coverage, one plan is the primary payer. It pays benefits first. The other plan is secondary. It pays benefits next. This process is known as "coordination of benefits." If we are the secondary payer, we may be entitled to receive payment from your primary plan. HNE decides which insurance is primary based on rules used throughout the insurance industry, or as required by law and applicable regulations. A copy of these rules is available upon request.

We will always provide you with the benefits described in this Member Handbook. However, HNE will only provide coverage under this Member Handbook to Members who have other health insurance

coverage if they follow HNE policies and rules. For example, if you see certain In-Plan Specialists without an HNE referral, HNE will not cover the services you receive.

What happens if I or one of my Dependents is enrolled in Medicare?

You must tell us and the Group Insurance Commission if you or a family member is enrolled in Medicare Part A or B. Medicare rules determine who has the first responsibility for paying for medical care. When HNE provides benefits to a Medicare eligible Member, HNE will coordinate coverage with Medicare according to Medicare rules.

What happens if I am entitled to benefits under another medical payment policy?

For Members who are injured and therefore entitled to benefits under the medical payment benefit of any other insurance policy, such as a homeowner's or auto insurance policy, such coverage will be primary to the coverage under this Member Handbook. When HNE provides benefits to a Member that the Member is eligible for under such other medical payment policy, HNE will coordinate coverage with the other carrier. If the other coverage entitles you to be directly reimbursed for certain medical expenses, you agree to allow the payment to be made directly to HNE.

What happens if I am injured at work? Will HNE pay for the services that I receive?

If HNE has information showing that services provided to a Member are covered under Workers' Compensation, employer's liability, or other program of similar purpose, or by a federal, state, or other government agency, HNE may suspend payment for such services until a determination is made whether payment will be made by such program. If HNE provides or pays for services for an illness or injury covered under Workers' Compensation, employer's liability, or other program of similar purpose, or by a federal, state, or other government agency, HNE will be entitled to recover its expenses from the provider of services or the party or parties legally obligated to pay for such services.

SUBROGATION

As an HNE Member, you agree to give HNE a right of subrogation and a right of reimbursement. These terms are explained in this section.

Who pays my medical bills if another party is responsible for my injuries or illness?

Occasionally, HNE pays medical bills for which another person (or his or her insurer) is legally responsible. HNE then has the right to make a claim against the third party to recover for the benefits and services provided. This is called subrogation.

For example, if you are in an accident and another party is liable for your injuries, HNE will file a lien to recover the provider's charges (i.e., the billed amount) for any benefits provided to you under this Member Handbook. HNE has a right to recover even if you do not receive full settlement. HNE's recovery is limited, however, to the amount you received by suit or settlement.

HNE also has the right to sue in your name at its expense. If a suit brought by HNE results in an award greater than the provider's charges, HNE then has the right to recover costs of the suit and attorney's fees out of the excess.

What if I have already received payment for my injuries?

If you receive payment from another party for injuries caused by the acts or omissions of a third party, HNE has a right of reimbursement. The right of reimbursement arises only after you receive payment for your injuries from a third party or that party's insurer. HNE then has the right to request reimbursement for the benefits and services provided to you.

If you receive payment from a third party, HNE will seek reimbursement from you for the provider's charges for the benefits and services provided to you. HNE's right to reimbursement applies even if you did not receive full settlement for your injuries. HNE will not ask for more than you received by suit or settlement.

What are my responsibilities as a Member when HNE decides to subrogate?

As a Member, it is your duty to cooperate with HNE and provide HNE with any documents and information needed to help HNE receive its repayment. You must not do anything to hinder or prevent HNE from pursuing this recovery. If you have a lawyer, you must ask him or her to cooperate as well. If you fail to cooperate or provide requested assistance, you may be liable for any expenses incurred by HNE, including reasonable attorney fees, in enforcing its rights under this Member Handbook.

SECTION 13 – OTHER PLAN ADMINISTRATION PROVISIONS

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- HNE and its Providers are independent contractors.
- HNE may amend this Member Handbook at any time.

Amendments

This Member Handbook is effective as of July 1, 2005. If you would like to know if HNE has made any changes to this Member Handbook, please call HNE Member Services.

HNE, with the agreement of the Group Insurance Commission, may amend this Member Handbook at any time if the amendments: (1) are not in violation of any law; (2) comply with applicable rules and regulations of the Massachusetts Division of Insurance; or (3) are required by law, regulation, or rule. These changes will apply to all agreements of this type, not just to this Member Handbook. These changes will be effective whether or not an individual Member in fact receives notice of the amendment. Changes will apply to all benefits or services provided after the Effective Date of the change.

Contracting Parties

Nothing in this Member Handbook will create or is meant to create any relationship between the parties other than that of independent contracting parties. The Group and HNE are independent entities, and neither party is the partner, agent, employee, or servant of the other.

Members and Other Third Parties

Except as specifically provided in this Member Handbook, this Member Handbook will not create any rights in a Member or any other person as a third party beneficiary of this Member Handbook.

Health New England and Providers

The relationship between HNE and its In-Plan Providers is a direct or indirect independent contractor relationship. As such, each party is at all times acting and performing as an independent contractor, and neither party will have or exercise any control or discretion over the method by which the other party shall perform such work or render or perform such services or functions. It is further expressly understood that no work, act, commission, or omission of any party, its employees, agents, or servants will be construed to make or render any party, its employees, agents or servants an employee, agent, servant, representative or joint venturer with, the other party.

Payment of Providers

HNE pays In-Plan Providers in a number of ways. For example, we may pay a set fee for each *service*, each *day* (of a hospital stay), or each *case*. We also may pay a set amount each month for each Member signed up with a provider or group of providers, regardless of whether the Member is actually

treated. (This payment is called a *capitation* payment.) In many cases, HNE assigns providers to a grouping or "pool" of providers. In these cases, HNE puts a part of each payment to the provider into his/her pool until the end of the year. If the pool meets set goals or targets, HNE will pay some or the entire amount put aside, or the full amount plus a bonus. HNE does not base payments or bonuses on denials of coverage of services.

Members and Providers

The relationship of a Member to a provider is based solely on the provider-patient relationship. Each provider is solely responsible for all health care services furnished to a Member.

Agreement Binding on Members

By enrolling in the Plan, or receiving benefits or coverage under the Plan, you agree to all terms and conditions of this Member Handbook. Subscribers will be responsible for their Dependents' compliance with this Member Handbook. Minor Dependents of Subscribers will be bound by the actions of the Subscriber.

Waiver

No waiver occurs if HNE fails to enforce any provision of this Member Handbook. HNE may enforce the provision at a future date. Similarly, no waiver occurs if HNE fails to enforce any remedy arising from a default under the terms of this Member Handbook.

Severability

If any part of this Member Handbook is declared not enforceable or not valid, such invalidity or unenforceability will not affect any other section or clause of this Member Handbook. The remaining sections or clauses of this Member Handbook will remain in full force and effect.

Governing Law

This Agreement will be governed and construed according to the laws of the Commonwealth of Massachusetts.

Conformance with Law

Each party agrees to carry out all activities that are taken pursuant to this Member Handbook in conformance with all applicable federal and state laws, regulations, rules, and policies.

Notices

Any notice under this Member Handbook may be given by United States mail, postage prepaid, addressed as follows:

To HNE:	President and Chief Executive Officer Health New England, Inc. One Monarch Place Springfield, MA 01144-1500
To a Subscriber/Member:	To the latest address on file with HNE

To the Group: Group Insurance Commission
P.O. Box 8747
Boston, MA 02114-8747

Circumstances Beyond HNE's Control

HNE will try to arrange for services in the case of major disasters. However, HNE will not be liable for any failure to provide or arrange, or for delay in providing or arranging, services or supplies in the event of any of the following: natural disaster, war, acts of terrorism, riot, civil insurrection, strikes, epidemic, or any other emergency or event caused by an act which is beyond the control of HNE.

SECTION 14 – NOTICE OF PRIVACY PRACTICES

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

HNE knows how important it is to protect your privacy at all times and in all settings. This Notice of Privacy Practices describes how Health New England ("HNE") may collect, use and disclose your protected health information, and your rights concerning your protected health information. "Protected health information" or "PHI" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by law to maintain the privacy of your protected health information. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) also requires us to provide you this notice about our legal duties and privacy practices. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace or modify it. We may change the terms of this notice at any time. The new notice will be effective for all protected health information that we maintain. We will mail a new Notice of Privacy Practices whenever we make a material change to the privacy practices described in this notice.

How does HNE protect my personal health information?

HNE has a detailed policy on confidentiality. All HNE employees are required to protect the confidentiality of your PHI. An employee may only access your information when they have an appropriate reason to do so. Each employee or temporary employee must sign a statement that he or she has read and understands the policy. On an annual basis, HNE will send a notice to employees to remind them of this policy. Any employee who violates the policy is subject to discipline, up to and including dismissal. If you would like a copy of HNE's Privacy Policy, you may request a copy from HNE Member Services. In addition, HNE includes confidentiality provisions in all of its contracts with In-Plan Providers. HNE also maintains physical, electronic, and procedural safeguards to protect your information.

How does HNE collect protected health information?

HNE gets PHI from:

- Information we receive directly or indirectly from you, your employer or benefits plan sponsor through applications, surveys, or other forms. For example, name, address, social security number, date of birth, marital status, Dependent information, employment information and medical history.

- Providers who are treating you or who are involved in your treatment and/or their staff when they submit claims or request authorization on your behalf for certain services or procedures.
- Attorneys who are representing our Members in automobile accidents or other cases.
- Insurers and other health plans.

How does HNE use and disclose my protected health information?
HIPAA and other laws allow or require us to use or disclose your PHI for many different reasons. We can use or disclose your PHI for some reasons without your written agreement. For other reasons, we need you to agree in writing that we can use or disclose your PHI.

Uses and Disclosures for Treatment, Payment and Health Care Operations. HNE uses and discloses protected health information in a number of different ways in connection with your treatment, the payment for your health care, and our health care operations. We can also disclose your information to providers and other health plans that have a relationship with you, for *their* treatment, payment and some limited health care operations. The following are only a few examples of the types of uses and disclosures of your protected health information that we are permitted to make *without* your authorization for these purposes:

Treatment: We may disclose your protected health information to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with your treatment. We may also disclose your protected health information to health care providers (including their employees or business associates) in connection with preventive health, early detection and disease and case management programs.

Payment: We will use and disclose your protected health information to administer your health benefits policy or contract, which may involve:

- Determining your eligibility for benefits;
- Paying claims for services you receive;
- Making medical necessity determinations;
- Coordinating your care, benefits or other services;
- Coordinating your HNE coverage with that of other plans (if you have coverage through more than one plan), to make sure that the services are not paid twice;
- Responding to complaints, appeals and external review requests;
- Obtaining premiums, underwriting, ratemaking and determining cost sharing amounts; and
- Disclosing information to providers for their payment purposes.

Health Care Operations: We will use and disclose your protected health information to support HNE's other business activities, including the following:

- Conducting quality assessment activities, or for the quality assessment activities of providers and other health plans that have a relationship with you;
- Developing clinical guidelines;
- Reviewing the competence or qualifications of providers that treat our Members;
- Evaluating our providers' performance as well as our own performance;

- Obtaining accreditation by independent organizations such as the National Committee for Quality Assurance;
- Maintaining state licenses and accreditations;
- Conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs;
- Business planning and development, including the development of HNE's drug Formulary;
- Operation of preventive health, early detection and disease and case management and coordination of care programs, including contacting you or your doctors to provide appointment reminders or information about treatment alternatives, therapies, health care providers, settings of care or other health-related benefits and services;
- Reinsurance activities; and
- Other general administrative activities, including data and information systems management and customer service.

Other Permitted or Required Uses and Disclosures of Protected Health Information. In addition to treatment, payment and health care operations, federal law allows or requires us to use or disclose your protected health information in the following additional situations without your authorization:

Required by Law: We may use or disclose your protected health information to the extent we are required to do so by law. For example, the HIPAA law compels us to disclose PHI when required by the Secretary of the Department of Health and Human Services to investigate our compliance efforts.

Public Health Activities: We may disclose your protected health information to an authorized public health authority for purposes of public health activities. The information may be disclosed for such reasons as controlling disease, injury or disability. We also may have to disclose your PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading the disease. In addition, we may make disclosures to a person subject to the jurisdiction of the Food and Drug Administration, for the purpose of activities related to the quality, safety or effectiveness of an FDA-regulated product or activity.

Abuse or Neglect*:* We may make disclosures to government authorities if we believe you have been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when we are required or authorized by law to do so.

Health Oversight: We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs, or its contractors (e.g., state insurance department, U.S. Department of Labor) for activities authorized by law, such as audits, examinations, investigations, inspections and licensure activity.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal and, in certain cases, in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose your protected health information under limited circumstances to law enforcement officials. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness or missing persons or to provide information concerning victims of crimes.

Coroners, Funeral Directors and Organ Donation: We may disclose your protected health information in certain instances to coroners, funeral directors and organizations that help find organs, eyes, and tissue to be donated or transplanted.

Threat to Health or Safety: If we believe that a serious threat exists to your health or safety, or to the health and safety of any other person or the public, we will notify those persons we believe would be able to help prevent or reduce the threat.

Military Activity and National Security: We may disclose your protected health information to Armed Forces personnel under certain circumstances and to authorized federal officials for the conduct of national security and intelligence activities.

Correctional Institutions: If you are an inmate in a correctional facility, we may disclose your protected health information to the correctional facility for certain purposes, including the provision of health care to you or the health and safety of you or others.

Workers' Compensation: We may disclose your protected health information to the extent required by workers' compensation laws.

Will HNE give my PHI to my family or friends?

We will only disclose your PHI to a member of your family (including your spouse), a relative, or a close friend in the following circumstances:

- You have authorized us to do.
- That person has submitted proof of legal authority to act on your behalf.
- That person is involved in your health care or payment for your health care and needs your PHI for these purposes. If you are present for such a disclosure (whether in person or on a telephone call), we will either seek your verbal agreement to the disclosure or provide you an opportunity to object to it. We will only release the PHI that is directly relevant to their involvement.
- We may share your PHI with your friends or family members if professional judgment says that doing so is in your best interest. We will only do this if you are not present or you are unable to make health care decisions for yourself. For example, if you are unconscious and a friend is with you, we may share your PHI with your friend so you can receive care.
- We may disclose a minor child's PHI to their parent or guardian. However, we may be required to deny a parent's access to a minor's PHI, for example, if the minor is an emancipated minor or can, under law, consent to their own health care treatment.

Will HNE disclose my personal health information to anyone outside of HNE?

HNE may share your protected health information with affiliates and third party "business associates" that perform various activities for us or on our behalf. For example, HNE may delegate certain

functions, such as medical management or claims repricing, to a third party that is not affiliated with HNE. HNE may also share your personal health information with an individual or company that is working as a contractor or consultant for HNE. HNE's financial auditors may review claims or other confidential data in connection with their services. A contractor or consultant may have access to such data when they repair or maintain HNE's computer systems. Whenever such an arrangement involves the use or disclosure of your protected health information, we will have a written contract that contains terms designed to protect the privacy of your protected health information.

HNE may also disclose information about you to your Primary Care Physician, other providers that treat you and other health plans that have a relationship with you, for their treatment, payment and some of their health care operations.

Will HNE disclose my personal health information to my employer?
In general, HNE will only release to your employer enrollment and disenrollment information, information that has been de-identified so that your employer can not identify you or summary health information. If your employer would like more specific PHI about you to perform plan administration functions, we will either get your written permission or we will ask your employer to certify that they have established procedures in their group health plan for protecting your PHI, and they agree that they will not use or disclose the information for employment-related actions and decisions. Contact your employer to get more details.

When does HNE need my written authorization to use or disclose my personal health information?
We have described in the preceding paragraphs those uses and disclosures of your information that we may make either as permitted or required by law or otherwise without your written authorization. For other uses and disclosures of your medical information, we must obtain your written authorization. Among other things, a written authorization request will specify the purpose of the requested disclosure, the persons or class of persons to whom the information may be given, and an expiration date for the authorization. If you do provide a written authorization, you generally have the right to revoke it.

Many Members ask us to disclose their protected health information to third parties for reasons not described in this notice. For example, elderly Members often ask us to make their records available to caregivers. To authorize us to disclose any of your protected health information to a person or organization for reasons other than those described in this notice, please call our Member Services Department and ask for an Authorization and Designation of Personal Representative Form. You should return the completed form to HNE's Enrollment Department at One Monarch Place, Springfield, MA 01144-1500. You may revoke the authorization at any time by sending us a letter to the same address. Please include your name, address, Member identification number and a telephone number where we can reach you.

What are my rights with respect to my PHI?
The following is a brief statement of your rights with respect to your protected health information:

Right to Request Restrictions: You have the right to ask us to place restrictions on the way we use or disclose your protected health information for treatment, payment or health care operations or to others involved in your health care. **However, we are not required to agree to these restrictions.** If we do agree to a restriction, we may not use or disclose your protected health information in violation of that restriction, unless it is needed for an emergency.

Right to Request Confidential Communications: You have the right to request to receive communications of protected health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you. We will accommodate reasonable requests. Your request must be in writing.

Right to Access Your Protected Health Information: You have the right to see and get a copy of the protected health information about you that is contained in a "designated record set," with some specified exceptions. Your "designated record set" includes enrollment, payment, claims adjudication, case or medical management records and any other records that we use to make decisions about you. Requests for access to copies of your records must be in writing and sent to the attention of the HNE Legal Department. Please provide us with the specific information we need to fulfill your request. We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies.

Right to Amend Your Protected Health Information: You have the right to ask us to amend any protected health information about you that is contained in a "designated record set" (see above). All requests for amendment must be in writing and on an HNE Request for Amendment form. Please contact the HNE Legal Department to obtain a copy of the form. You also must provide a reason to support the requested amendment. In certain cases, we may deny your request. For example, we may deny a request if we did not create the information, as is often the case for medical information in our records. All denials will be made in writing. You may respond by filing a written statement of disagreement with us, and we would have the right to rebut that statement. If you believe someone has received the unamended protected health information from us, you should inform us at the time of the request if you want them to be informed of the amendment.

Right to Request an Accounting of Certain Disclosures: You have the right to have us provide you an accounting of times when we have disclosed your protected health information for any purpose other than the following:

(i) treatment, payment or health care operations;
(ii) disclosures to others involved in your health care;
(iii) disclosures that you or your personal representative have authorized; or
(iv) certain other disclosures, such as disclosures for national security purposes.

All requests for an accounting must be in writing. We will require you to provide us the specific information we need to fulfill your request. This accounting requirement applies for six years from the date of the disclosure, beginning with disclosures occurring after April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee.

Right to Request a Copy of this Notice: If you have received this notice electronically, you have the right to obtain a paper copy of this notice upon request.

Who should I contact if I have a question about this notice or a complaint about how HNE is using my personal health information?

Complaints and Communications With Us. If you want to exercise your rights under this Notice, communicate with us about privacy issues, or if you wish to file a complaint with us, you can write to:

Health New England, Inc.
Complaints and Appeals Department
One Monarch Place
Springfield, MA 01144-1500

You can also call us at 800-310-2835 or 413-787-4004. You will not be retaliated against for filing a complaint with us.

Complaints to the Federal Government. If you believe your privacy rights have been violated, you also have the right to file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint with the federal government.

SECTION 15 – DISCLOSURES REQUIRED BY LAW

SOME IMPORTANT THINGS TO KNOW ABOUT THIS SECTION

- This section contains information which the law requires HNE to disclose to its Members.

Quality Management Program

The HNE Quality Management Program is developed annually to address the quality and safety of clinical care and the quality of services provided to the Plan's Members. The written program description defines our quality management program structure, objectives, processes, and resources used to identify, review, measure, monitor, and evaluate the activities implemented by HNE to meet the goals of the program.

HNE also develops a Quality Management Work Plan annually. This is the listing of activities that are implemented to meet our program goals. Projects focusing on patient safety, behavioral health issues, utilization of services, Member and provider communications, confidentiality, disease management, prevention, and continuity of care for Members have been implemented. The time frame for completion of each project is very different. Some are very simple, can be completed in a matter of months, while others are ongoing, and will be followed by HNE throughout the year.

The Plan's Board of Directors has made the Quality Management Committee responsible for the performance of the Plan. The HNE Quality Management Committee meets about six times a year to review and monitor the progress of the activities listed in the Work Plan. Participation by individual HNE network providers is also essential to the functioning of the Quality Management Program.

If you would like any information regarding the HNE Quality Management Program Description or Work Plan, please contact the Quality Operations Manager at 413-233-3435. HNE will provide this information on request.

Summary Description of the Process by which Clinical Guidelines and Utilization Review Criteria are Developed

HNE has a written program for how health care service and delivery are reviewed. The program is made up of activities in the areas of utilization, case, and disease management. Its purpose is to help Members to receive the appropriate care. HNE may conduct reviews before or during the delivery of services. HNE uses nationally recognized guidelines and resources for these reviews. HNE also uses criteria that it develops with the input of local practicing physicians. Physicians outside the HNE staff may be consulted to help make a decision of medical appropriateness. Non-physicians can make a decision to approve care or services. Only HNE Medical Directors can make a decision to deny coverage for reasons of medical necessity. At times, HNE may delegate certain utilization

management functions to other entities. When this occurs, HNE requires the entity to use program procedures and criteria approved by HNE. HNE annually reviews its utilization review program.

Summary Description of HNE's Procedures in Making Decisions about the Experimental or Investigational Nature of Individual Drugs, Medical Devices, or Treatments in Clinical Trials

HNE has several programs to address this area. In general, the decision process is as follows:

- HNE uses Hayes, Inc. to research new and emerging medical technologies. Hayes also researches new uses of existing technologies. The research is structured and evidence-based. Analyses of market, regulatory, legal, ethical, and actuarial issues are part of the study. Hayes then makes coverage recommendations to HNE.
- To evaluate drugs, HNE uses Express Scripts®, Inc. Express Scripts® uses a committee of physicians and pharmacists to review new FDA-approved drugs that have been available in the United States for at least six months. Some of the criteria used to evaluate drugs are:
  - Safety.
  - The potential effects of treatment under optimal circumstances.
  - The actual effects of treatment under real life conditions.
  - Potential health outcomes and resulting total cost of drugs and medical care, and potential savings available.
  - Any restrictions needed to assure safe, effective, or proper use of the drug, patient outcome, or cost effectiveness.
- The recommendations by Hayes and Express Scripts® are then screened by an internal HNE committee. If more medical input is needed, an In-Plan physician will be consulted. He or she will provide a written opinion to HNE.
- The findings are then reported to another HNE committee, which includes In-Plan physicians, for discussion at its next meeting. This allows for local practicing physician input.
- Recommendations will then go to the HNE Medical Policy Committee for final decision. The committee makes a decision based on its review of the recommendations and other HNE-specific data, such as:
  - Prevalence of disease(s) associated with proposed technologies.
  - Benefits to HNE Members.
  - Cost.
  - Use of current technologies and projected use of new technology.

HNE does not cover any experimental or investigational device or treatment unless it has been reviewed and approved by HNE's Medical Technology Assessment Committee.

Continued Treatment (Transitional Care)

Provider disenrollment and continuation of coverage requirements:

There are times when HNE will allow you to continue to receive coverage for care after your doctor disenrolls. Those circumstances are:

- If your PCP disenrolls. HNE will notify you at least 30 days before the disenrollment of your PCP. HNE will permit you to continue to see your PCP for a period of 30 days after your PCP is disenrolled. HNE will also allow a Member who is in active treatment for a chronic or acute condition to continue to see his or her PCP through the current period of active treatment or up to 90 days after the PCP is disenrolled, whichever is shorter. You will not be allowed to continue to see your PCP if your PCP is disenrolled for reasons related to quality or for fraud. If your PCP is disenrolled, HNE will send you a letter to notify you and to advise you to call HNE to select a new PCP. If you do not select a new PCP, HNE will assign one to you.
- If your specialist disenrolls. HNE will notify you at least 30 days before the disenrollment. HNE will help you to select a new specialist if you would like. HNE will let a Member who is in active treatment for a chronic or acute condition to continue to see the specialist through the current period of active treatment or for up to 90 days after the specialist is disenrolled, whichever is shorter. You will not be allowed to continue to see this provider if he or she is disenrolled for reasons relating to quality or for fraud.
- If a provider who is treating pregnant Members is involuntarily disenrolled. If this occurs and you are in your second or third trimester of pregnancy, HNE will permit you to continue treatment with your provider through the postpartum period. You will not be allowed to continue to see this provider if he or she is disenrolled for reasons related to quality or for fraud.
- If a provider who is treating terminally ill Members is involuntarily disenrolled. If this occurs and you are terminally ill, HNE will permit you to continue treatment with your provider until your death. You will not be allowed to continue to see this provider if he or she is disenrolled for reasons related to quality or for fraud.

Transitional coverage for new Members:

HNE will provide coverage for a new Member to continue to see an Out-of-Plan Provider for up to 30 days from the Effective Date of coverage if:

- The Member's employer only offers the Member a choice of carriers in which the physician is not a participating provider, and
- The physician is providing the Member with an ongoing course of treatment or is the Member's PCP.

With respect to an insured in her second or third trimester of pregnancy, this provision will apply to services rendered through the postpartum period. With respect to an insured with a terminal illness, this provision will apply to services rendered until death.

Requirements for transitional coverage:

In all of the above circumstances, HNE will only permit a Member to continue coverage if their provider agrees:

- To accept payment from HNE at the rates applicable to participating providers or at the rates considered payment in full prior to the notice of disenrollment.

- Not to require the Member to be responsible for cost sharing that exceeds the amount that could have been required if the provider participated with HNE or if the provider had not been disenrolled.
- To adhere to HNE's quality assurance standards and to provide HNE with necessary medical information related to the care provided.
- To adhere to HNE's policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing services pursuant to a treatment plan, if any, approved by HNE.

Nothing in this section will be construed to require the coverage of benefits that would not have been covered if the provider involved remained an In-Plan Provider.

Premium Rates and Payment Arrangements (Prepaid Fees)

With HNE, your employer pays a prepaid monthly fee ("premium") on your behalf for HNE benefits. The premium is due on or before the first day of the billing period to which it applies. The premium rates are shown in the Group Insurance Commission contract. The Commission must send HNE the premium due for each Subscriber.

The rates charged may change from year to year, or at other times, in accordance with the terms of the Group Insurance Commission contract. The Commission has the responsibility to notify its employees of the premium rate charge or of any changes in the charge. Any such change will take effect on the date specified in the Group Insurance Commission contract. If you would like to find out what the premium is for your coverage, please contact your Group Insurance Coordinator at your work site, or the Group Insurance Commission.

Notice of Termination for Nonpayment of Premiums

HNE will not deny a Member's claim for covered health care services on the grounds that prior to the date covered health care services were received, the employer's plan had been terminated for nonpayment of premiums, unless HNE has sent written notice of the termination to the Member prior to the date the covered health care services were received.

Pediatric Specialty Care

HNE will provide coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to Members requiring such services.

Physician Profiling Information

Physician profiling information, so called, is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts. You can request a physician printout by calling 800-377-0550.

HNE's Involuntary Disenrollment Rate

HNE's involuntary disenrollment rate is 0%.

SECTION 16 – DEFINITIONS

Adverse Determination – A decision, based upon a review of information provided, to deny, reduce, change, or end coverage of a health service for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

Agreement - This Member Handbook, any amendments, and the Group Insurance Commission contract between your Group and HNE.

Calendar Year – The 12-month period beginning January 1 and ending December 31.

Copayment - The amount specified in this Member Handbook or any amendments to this Member Handbook that you are required to pay when receiving Covered Services.

Covered Services - Medically Necessary Services and benefits to which you are entitled, as set forth in this Member Handbook.

Custodial Care – Custodial Care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, HNE considers the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

Dependent - Any person who meets the Dependent requirements of Section 7, who is enrolled, and for whom HNE has received the premium specified in the Group Insurance Commission contract.

Effective Date - The date on which coverage begins under this Member Handbook.

Emergency - A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Employer Group Agreement - An Agreement between your Group and HNE that details premium rates, Effective Date, and other obligations.

Formulary - A list of preferred brand name drugs offered to Members for a higher Copayment than generic drugs.

Group - The Commonwealth of Massachusetts Group Insurance Commission.

Hospital Services - Those Covered Services that are usually provided by acute care general hospitals in the Service Area and which are prescribed or approved by an In-Plan Doctor.

Identification Card (ID Card) - The card that HNE issues to a Subscriber upon enrollment and which must be presented at the time of service.

Infertility – The inability of an individual (or couple), who should expect fertility as a natural state, to conceive during a period of at least one year of attempting to conceive.

In-Plan Doctor - A licensed doctor or oral surgeon who has an existing agreement with HNE to provide certain Covered Services to Members. HNE and the In-Plan Doctor are independent entities, and neither party is the agent, employee, or servant of the other.

1. Primary Care Physician (PCP) - An In-Plan Doctor who has been designated by HNE to be primarily responsible for providing or arranging for Covered Services to Members.
2. In-Plan Specialist - An In-Plan Doctor who is eligible to provide a specialty service and who has agreed with HNE to provide such services.

In-Plan Hospital - A licensed acute care general hospital that has agreed with, and been designated by, HNE to provide Hospital Services. HNE and the In-Plan Hospital are independent entities, and neither party is the agent, employee, or servant of the other.

In-Plan Provider - Any hospital, doctor, health care facility, agency, organization, pharmacy, or person that is properly licensed or otherwise authorized to furnish health care services and which has agreed with HNE to provide Medically Necessary Services to HNE Members. HNE and the In-Plan Provider are independent entities, and neither party is the agent, employee, or servant of the other.

In-Plan Specialty Referral Form - The HNE document that is completed and signed by an In-Plan Doctor to arrange for services with certain In-Plan Specialists. This referral must be presented to the provider before or at the time services are rendered.

Medically Necessary Services - Those Covered Services and supplies that HNE's Medical Director determines are (a) essential for the treatment of a Member's medical condition, (b) in accordance with generally accepted medical practice, and (c) provided at an appropriate facility and at the appropriate level of care for the treatment of a Member's medical condition in accordance with generally accepted standards in the medical community.

Member - Any person who is enrolled in HNE and has a right to services under this Member Handbook.

Non-Formulary - Any brand name drug that is not listed on the Formulary.

Open Enrollment Period - That period of each contract year when, by agreement between HNE and the Group, eligible persons may enroll or when Members may transfer from the Plan to an available alternate health benefits plan without any lapse in coverage.

Out-of-Plan Provider - Any licensed provider who is not an In-Plan Provider.

Prior Approval – The process by which HNE reviews and approves coverage for certain services before the services are performed.

Qualified Beneficiary - Persons who are covered under a Group health benefit plan on the day before a COBRA Qualifying Event.

Qualifying Event – A loss of coverage that would make a Qualified Beneficiary eligible to receive continuation coverage under COBRA.

Service Area - The area in which HNE is authorized to operate as a managed care plan.

Subscriber - A person who meets the eligibility requirements of Section 7, who is enrolled, and for whom HNE has received the premium specified in the Group Insurance Commission contract.

Tier – A Copayment level where the amount that the member must pay for a covered service or item depends on: a) the type of service or item; or b) where it is received. Generally, you pay more for a service or item at a higher numbered Tier, and less for a service or item at a lower numbered Tier. For example, the Tier 2 copayment is higher than the Tier 1 copayment.

APPENDIX A: GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

This notice contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

WHAT IS COBRA COVERAGE? COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and Dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or Dependents. The GIC administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2301, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa**.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the GIC's Health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "Qualifying Events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth ends (for any reason other than gross misconduct) or his/her hours of employment are reduced; or
- You and your spouse divorce or legally separate.

If you have Dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "Qualifying Events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced;
- The parents divorce or legally separate; or
- The Dependent ceases to be a Dependent child (e.g., is over age 19 and is not a full time student, or ceases to be a full-time student).

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other Qualifying Events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial Qualifying Event) if a second Qualifying Event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second Qualifying Event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial Qualifying Event) if any Qualified Beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another Qualified Beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the Qualified Beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A Qualified Beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. The GIC has no involvement in the

conversion programs, and you pay premiums to the health plan for the conversion coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the Qualifying Events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced;
  - The employee or former employee dies;
  - The employee divorces or legally separates;
  - The employee or employee's former spouse remarries;
  - A covered child ceases to be a Dependent;
  - The Social Security Administration determines that the employee or a covered family member is disabled; or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P.O. Box 8747, Boston, MA 02114-8747.

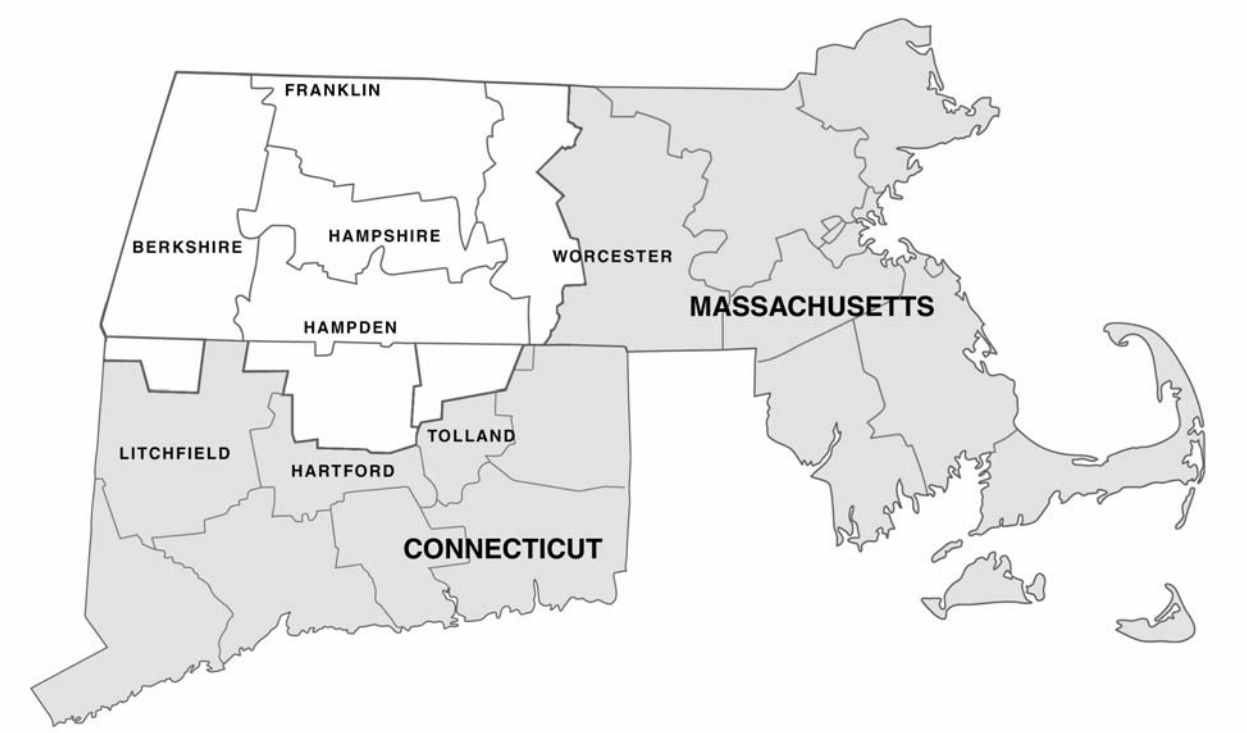
Notes:

Notes:

Benefit Package S2

Print Date: June 2006

HEALTH NEW ENGLAND SERVICE AREA



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